VANCOUVER ISLAND
health authority

Integration Plan 2007

March 22, 2004
(Edited July 2004 to include Redesign and Budget Management Plan 2004/05-06/07)

Integration Plan 2007
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Executive Summary

The first strategic plan for the Vancouver Island Health Authority (VIHA), entitled Integration Plan 2007 is now complete. The document was shared in draft form with staff and other stakeholders for their review and comment from January to March 2004. All comments and suggestions have been reviewed and considered in preparing the final document.

Integration Plan 2007 is a high level strategic document that sets the stage for future service delivery. It will be updated on an annual basis, and facilitates the development of the Ministry of Health three-year rolling Redesign and Budget Management Plans, which are included in Appendix B. The Integration Plan incorporates the vision, mission, values, goals and major strategies for VIHA to the year 2007. Performance indicators and three-year targets have been identified where possible.

The Integration Plan has been developed from both a population and service perspective. The Plan focuses on specific population groups where there is a clear need, and an ability to influence health, including: children and youth, frail elderly, aboriginal peoples, chronically ill, adults and seniors with mental illnesses and addictions, the downtown/hard to serve, persons with disabilities and rural and remote populations.

Sector specific planning is also included. VIHA recognizes the need to shift from a system focused on managing illness to one that delivers a seamless, integrated array of services. Such a shift challenges the traditional way health professionals have delivered and managed services and requires a realization that health and wellness is a personal responsibility. Meeting the complex needs of populations at risk will require new service delivery models. Service delivery in the future will necessarily look vastly different than today.

Future planning in VIHA will be focusing on the population and their health needs, and the anticipated changes in delivery of health services. Planning will proceed with specific attention to the flow of clients throughout the system. Recognizing that bottlenecks in the system arise largely at the point where a client moves from one service to another, such as the move from hospital to residential care or from community to hospital.

Work is also underway to develop an infrastructure which will support the strategic direction of the organization. Initial plans have been developed for human resources, physician resources, information systems, business development, quality improvement, strategic communications and capital. Future plans to be developed include research and education and organization design.

The Integration Plan will be continually reviewed and updated on an annual basis. Further development and refinement will occur with each reiteration. This version provides a foundation for more detailed planning at the service and population levels.

1.0 Introduction: The Need to Plan for an Integrated Future

The Vancouver Island Health Authority (VIHA) is one of six health authorities in British Columbia, established in December 2001. VIHA is responsible for providing a wide range of health services to about 700,000 people across a large and diverse geographic area.

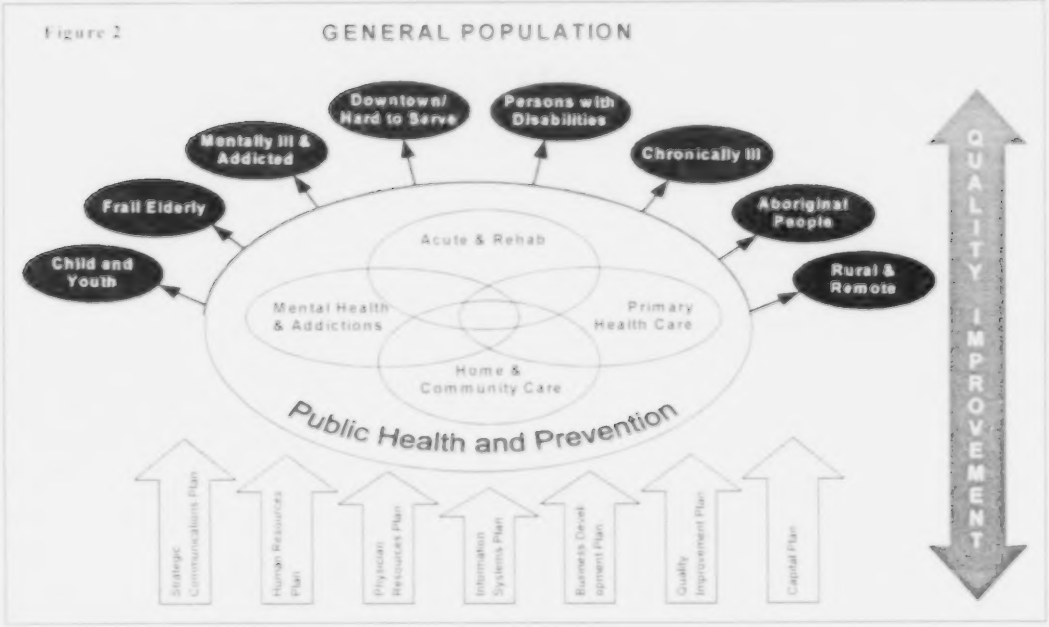
In November 2002, the Board of Directors approved a "plan to plan" to help integrate the newly established health authority and to set the direction for future service delivery. The first Plan is now complete and is outlined in this document. The Integration Plan is a high level strategic document to the year 2007, which will be updated annually.

Figure 1

In this document the vision, mission, values, goals and major strategies for VIHA to the year 2007 are outlined. Performance indicators and three-year targets have been identified where possible. The indicators will be refined and adapted with each update to the Plan. Progress in achieving the indicators and targets will be monitored on an ongoing basis using the Balanced Scorecard approach. On an annual basis, strategic initiatives will be identified (Figure 1).

The Integration Plan has been developed from both a population and service perspective. The Plan focuses on specific population groups where there is a clear need, and an ability to influence health. Sector specific planning is also included. It is recognized that future health services cannot be planned purely as an extension of the past. The strategic direction for major service sectors, as well as the infrastructure necessary to support the strategic direction are provided. The schematic below shows the various components of the Integration Plan (Figure 2).

Figure 2



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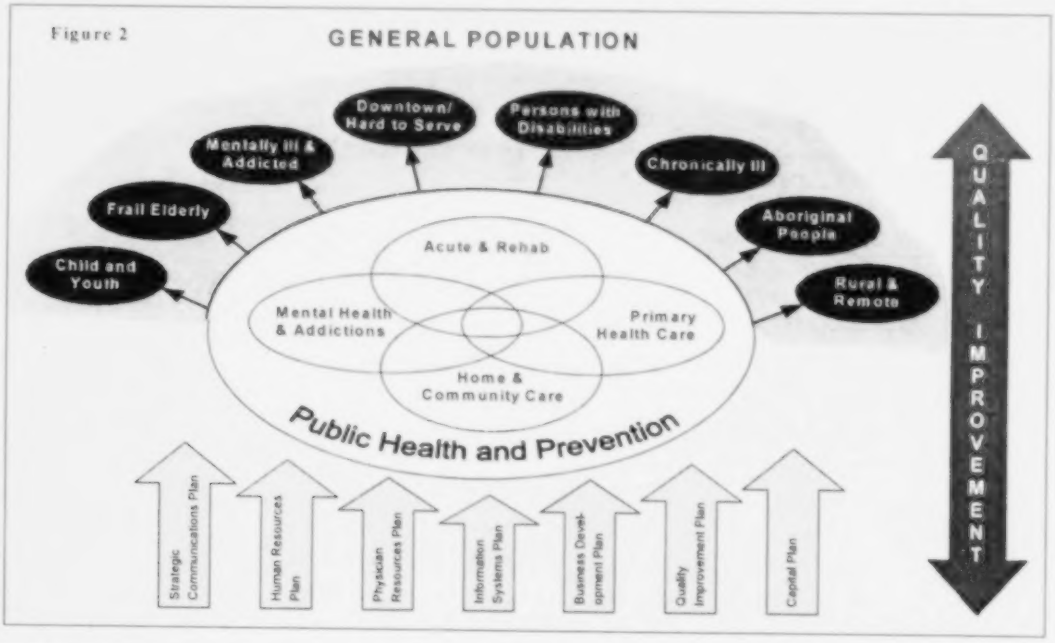


Quick Statistics...

The Vancouver Island Health Authority:

- *serves 700,000 people;*
- *operates 138 facilities throughout 56,000 square kilometers of varied geography;*
- *employs approximately 16,000 health service workers and 1,350 physicians;*
- *operates with an annual budget of $1.1 Billion;*
- *provides approximately 1,600 acute care beds and 5,000 residential care beds.*

On a typical day there are...

- *15 births, including 3 to mothers 35 and over, and 1 to a mother under the age of 20;*
- *17 deaths, including 5 from cancer, 4 from heart disease and 1 from stroke related illness;*
- *201 admissions to hospital including 92 admitted from the Emergency Room;*
- *670 visits to the Emergency Room;*
- *14 people with mental illness admitted to hospital;*
- *33 MRIs and 127 CT scans;*
- *148 surgeries;*
- *5,722 home care clients- 5,195 for home support, 429 for nursing care and 98 for rehabilitation;*
- *60 children under the age of 2 immunized; and*
- *14 restaurant inspections.*

2.0 Vancouver Island Health Authority (VIHA): Who We Are

VIHA's geographic area covers 56,000 square kilometers and includes Vancouver Island, the Gulf and Discovery Islands and a small mainland area opposite northern Vancouver Island. The area includes many remote and isolated communities such as Quatsino, Sointula, and Alert Bay that are only accessed by water or air. To accommodate the diverse needs of its various communities, VIHA is divided into three health service delivery areas: South, Central, and North.

VIHA provides a full range of dynamic and progressive health programs and services. Services include hospital care, residential care, assisted living, home care, home support, as well as environmental and public health services. Most of the health needs for VIHA residents are met within the Health Authority. Residents are only required to leave for highly specialized needs, such as organ transplants and pediatric open-heart surgery.

VIHA is governed by a nine-member, government appointed Board of Directors. Board members were chosen to represent the interests of people throughout the health authority, not specific communities. An 11-member executive team provides leadership in the planning, management and delivery of health services across the entire region.

3.0 The Challenges We Face

The challenges facing VIHA in planning include a diverse and aging population, disparities in health status throughout the health authority and a number of complex service delivery issues, such as the recruitment and retention of appropriate health professionals. These challenges are described in the following pages.

a) Diverse and Aging Population

The population of VIHA represents 17% (695,942) of the provincial population. The most notable difference between the VIHA population and the rest of the province is the proportion of seniors. VIHA has a growing and aging population. Within VIHA, 8.5% of the population is older than 75 compared to just 6.3% for the province. The proportion of people aged 85 and older is 2.2%, also the highest in the province (1.6% for the province). Vancouver Island has six of the ten oldest communities in Canada.

VIHA has the highest percentage of population aged 85 and over in the province.

By 2007, the population of VIHA is projected to grow by 2.8% (19,372 residents). Communities with the largest anticipated growth include Qualicum, Sooke, Nanaimo, Ladysmith and the Gulf Islands (See Figures 3 and 4).

Figure 3 – VIHA Population - % Growth by Gender (2002-2007)

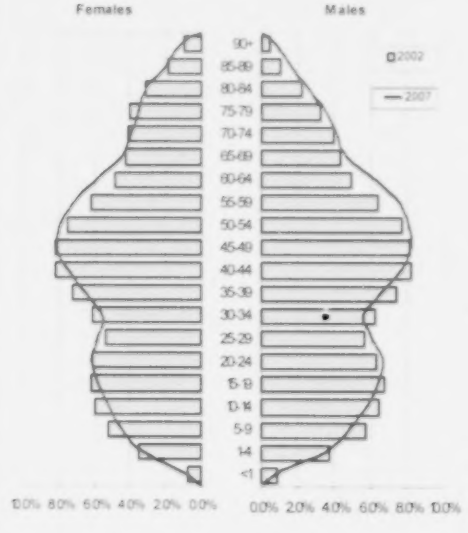
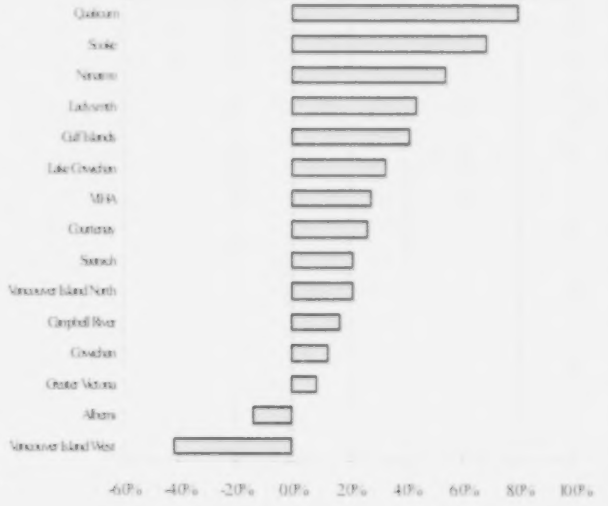


Figure 4 – VIHA Population - % Growth by Community (2002-2007)



Data source: PEOPLE 28 BC STATS, Ministry of Health Planning, Health Data Warehouse

The most significant increase between now and 2007 will be in the population over the age of 85, which is projected to increase by 28% (4,224 residents). The population growth of this elderly population will not be evenly distributed throughout the health authority. Most people aged 85 and older currently live in the South. The largest growth, however, will occur in the Central Area of the health authority, where a 51% increase (2,219 residents) is expected by the year 2007 and a 90% (3,897 residents) increase by the year 2012 (See Figure 5). Communities expected to have the most growth in the population over the age of 85 include: Qualicum, Saanich, the Gulf Islands and Ladysmith (See Figure 6).

Figure 5: % of Population Aged 85+ by HSDA

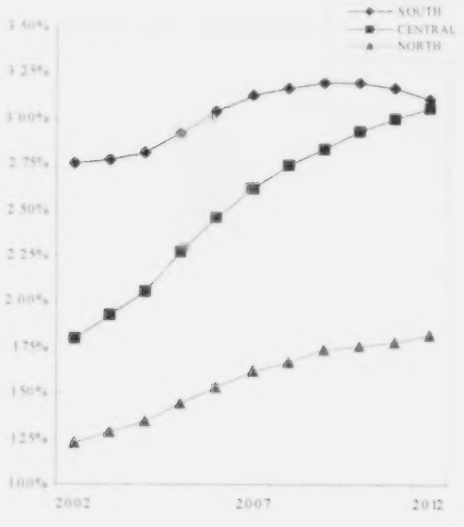
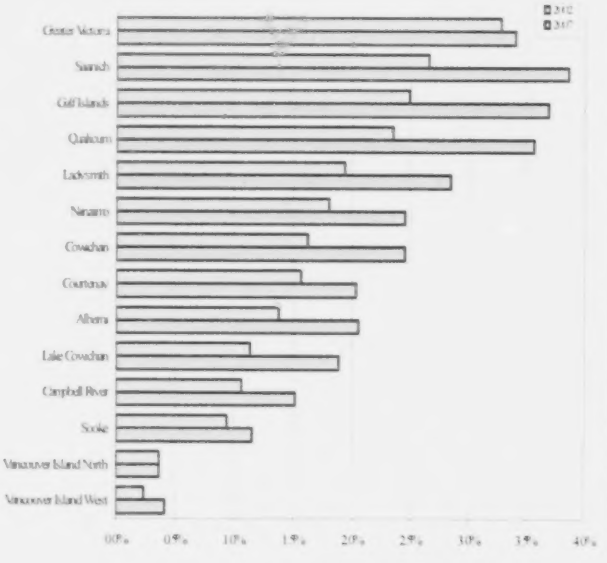


Figure 6: Growth in the Proportion of the Total Population Aged 85+ (2002-2007)



Data source: PEOPLE 28 BC STATS, Ministry of Health Planning, Health Data Warehouse

In addition to the growing senior population, the "baby boomer" population (aged 38-57) is forecasted to increase by about 8% by 2007. While the impact of the aging baby boomer is still debated, it is anticipated that they will be more informed than past consumers and will demand more choice and options. The first wave of "baby boomers" will be 65 years old in 2012. (See Appendix A for more detailed population data).

b) Disparities in Health Status

Relative to the rest of the province and the country, the health status of residents served by VIHA is good. However, there is variation in the health status of residents throughout the health authority. Residents in the South of VIHA appear to have comparable health status to the rest of the province. Health status worsens further north within the region and in communities with high aboriginal populations. (See Appendix A for aboriginal health status data)

The health and wellness of individuals is determined by a number of factors other than health services. These factors include: genetics, living and working conditions, income, social status, physical environment, personal health practices, and coping skills. Research shows that living and working conditions have a larger impact on people's health than health services. Societies that are prosperous and have an equitable distribution of wealth have the healthiest populations, regardless of the amount they spend on health services (Regionalization Research Centre 2000).

Reports from the Provincial Health Officer have repeatedly supported this relationship in B.C., showing that regions with the highest levels of education have the lowest levels of poverty, the least unemployment, and the highest rate of healthy behaviors. The data available in VIHA supports this and suggests a direct relationship between health status and employment and income.

The map below shows the unemployment rate within the health authority.

VIHA Health Status Facts...

- Premature death before age 75 is more likely in the Central and North areas. Compared to the South, the Central and Northern areas have 12% and 18% more years of life lost before age 75, respectively.
- Infant death rate is 59% higher in the North compared to the rest of the Health Authority.
- People in the North live on average two to three years less than the rest of the Health Authority.
- Teen pregnancy rate is 36% higher in the North and 29% higher in Central than in the South.
- More people are obese in Central (15%) and the North (13%) compared to the South (11%).
- Self-esteem is lowest in the North, with just 35% of the population reporting high self-esteem compared to 43% in Central and 52% in the South.

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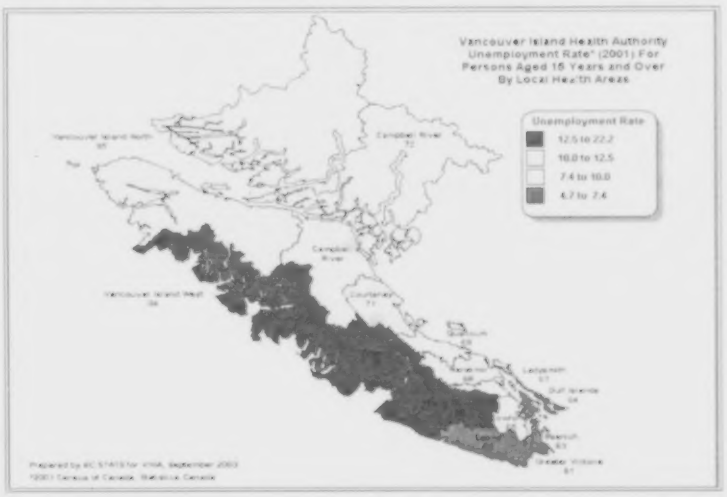

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- *More people are obese in Central (15%) and the North (13%) compared to the South (11%).*
- *Self-esteem is lowest in the North, with just 38% of the population reporting high self-esteem compared to 43% in Central and 50% in the South.*

The relationships between income and health are complex. An easy explanation is that poorer health in lower income groups is associated with living conditions. This is likely only part of the explanation since it does not explain why health differs within a similar socio-economic group. Research has shown that the degree of control people have over their lives, especially stressful situations and their discretion to act, are key influences on health. Higher income and status provides more options, which generally result in more control and discretion.

It is clear that many of our future health problems cannot be solved by the provision of health services alone. We recognize the importance of paying attention to the broad determinants of health and will work with community partners to implement prevention and protection programs, to support residents in making healthy lifestyle choices. We will focus on specific populations where there is a need and we have an ability to influence health.

c) Service Delivery Issues

When planning ahead to the year 2007, VIHA faces a number of major service delivery challenges, which are outlined below.

Human Resources

- Recruitment and retention of health professionals and physicians will continue to be a challenge. Across Canada and in many other countries in the world, shortages of certain professionals, such as nurses, pharmacists, and physician specialists create a "sellers" market where health professionals can choose from several employment offers.

- Within VIHA, the distribution of health professionals presents additional difficulties. For example, recruitment and retention of nurses and specialists are particularly challenging in the North Island. Family physicians are in short supply in certain communities in both the Central and North areas.

- For family physicians, two related trends have emerged. Fewer family physicians are providing a full-service family practice. New demands for continuity of care and chronic disease management are challenging family physicians to alter their traditional methods of medical practice. New configurations of service delivery are necessary to optimize scarce human resources.

- VIHA is mindful of the relationship between workloads and job satisfaction, and between provider satisfaction and the quality of health services. The challenge is to develop new methods of service delivery that meet the needs of the population and provide quality of work life for health providers.

New Technology And Innovation

- While new technologies can and do provide improvements in diagnosing and treating illnesses, they can be expensive and require significant resources for training and implementation. As funding to support new technology and equipment is scarce, rigorous technology and financial assessment must demonstrate compelling human and financial benefit.

Financial Pressures

- VIHA is facing significant financial pressures from increased wages and benefits to health care professionals, as well as inflationary costs associated with new technologies, medical supplies and drugs, and necessary investments in facilities and equipment.

Information and Technology

- The amalgamation of several health agencies into one health authority can be greatly advanced by computer technology and information processing. Computer technology is a powerful enabler and is a unifying force in the amalgamation process. Five major issues that must be addressed by VIHA are:
  - creating an electronic health record to enhance health service delivery;
  - developing a common computer communications network as the ability to communicate is critically important to provide optimum patient care, particularly in remote areas;
  - integrating business approaches - for example, aligning and standardizing policies across the organization;
  - standardizing use and application of software such as payroll and health records systems;
  - creating sources of funding to acquire and implement the technology.

- Each of these issues requires significant investment and human resources. Considerable effort and innovation will be required over several years to build an information system that can support VIHA's mandate within existing resources.

Rural and Remote Population

- About 20% of VIHA's population lives in rural areas (compared to15% in the province). The geographic area covers 56,000 square kilometers and includes Vancouver Island, the Gulf and Discovery Islands and a small mainland area opposite northern Vancouver Island. The area includes many remote and isolated communities such as Quatsino, Sointula, and Alert Bay that are only accessed by water or air.

Aging Infrastructure and Equipment

- The average age of VIHA facilities is 33 years. These facilities will eventually need to be replaced, upgraded or closed. The technology that is used to deliver care and service is also aging and requires a replacement strategy. For example, medical imaging equipment ranges from new to 26 years old.

- Securing and/or identifying dedicated funding to support capital acquisition and replacement continues to be a challenge in spite of the ongoing successful fundraising efforts of the foundations and auxiliaries as well contributions from the Regional Hospital Districts.

Public Expectations

- Public expectations of the system are increasing as a result of increasing access to information about health conditions and treatment options. Pressure is increasing to fund new technologies, drugs, and clinical interventions regardless of proven effectiveness or cost benefit.

- In addition, there is growing tension between a collective responsibility to health care and one that requires a greater personal responsibility for individual lifestyle choices. There is debate on the impact of people having the ability to pay to access more timely services.

4.0 A Vision For The Future

In order to address the considerable challenges that face us from now to 2007 and beyond, our decisions and actions must be grounded in a set of over-arching principles. Over the last two years, VIHA has developed a vision statement, clarified its mission, and established a set of fundamental values that will create the strategic context for the Integration Plan.

Vision, Mission and Values

Vision:

Healthy People, Healthy Island Communities, Seamless Service.

Mission:

To serve and involve the people of the islands to maintain and improve health.

Values:

As health care professionals and service providers we are committed to:

- ***Care, Compassion and Respect***: Of fundamental importance to us as health care professionals/service providers is the care, compassion and respect for the well-being and dignity of all those we serve and work with.

- ***Quality and Excellence***: Our highest priority is quality and the services we provide. We continue to strive for excellence, and are committed to evidence-based improvements.

- ***Competence and Knowledge***: We ensure we have the knowledge, skills, and tools, to respond to service needs and improve the health of the population, now and in the future.

- ***Partnership and Collaboration***: We recognize that the delivery of health care is complex and relies on the connection and collaboration of many. We work in partnership and share responsibility with our colleagues, clients, communities, and municipal and government organizations to integrate services and improve population health.

- ***Integrity, Accountability and Ethics***: We fulfill our duties and obligations and honour our commitments to each other and to every person we serve. We communicate with openness and honesty. We hold ourselves to the highest ethical standard in our work and take responsibility for the consequences of our actions.

- ***Creativity and Innovation***: We fill needs creatively and seek new ways of looking at old problems. We support advancements in health by seeking, facilitating and promoting learning, research and education.

- ***Pride and Recognition***: We value everyone's contribution and commitment to excellence. We demonstrate pride in self and in our organization.

- ***Diversity***: Our programs recognize and accommodate the unique needs of diverse populations.

- ***Client Focus and Integration***: We strive for a seamless system readily navigated by our clients.

- ***Sustainability***: We must be wise in balancing the services we provide with the resources available in order to ensure a sustainable system. We invest in what is effective in meeting needs, and we ensure that services are managed with efficiency.

Achievement of the Vision

The following describes what the system looks like once the vision is achieved.

The vision for VIHA is
"Healthy People, Healthy Island Communities, Seamless Service."
Achieving this vision would lead to…

- Clients who are well informed and are fully involved in decisions with respect to their health.
- Clients navigating through the health system easily and quickly, as their need for services changes
- Services which are appropriate and meet the health needs of the population.
- Patient and client records available electronically to authorized health service providers and the individual anywhere, anytime, in support of high quality health service. Patients and clients no longer have to repeat health histories or tests for each service provider they see.
- People increasingly taking responsibility for their own health.
- Services scheduled around the needs of the client not the provider.
- Clients able to access quality care or service no matter where they live.
- Clinical decisions supported by readily accessible evidence.
- Multidisciplinary, comprehensive health centres serving as the first point of contact for the public. Such centres provide a range of non-specialized services with a focus on lifestyle, disease prevention and screening (24 hours a day, 7 days a week).
- Clients supported in the community as long as they are able and wish to do so.
- Clients requiring residential care having options that respect privacy, dignity and choice.
- More options provided for end of life care.
- In-patient hospital services being mainly for the very ill or complex care requirements.
- Patients not kept in hospital beyond the required length of stay.
- Reasonable waits for hospital care – surgical wait lists are managed based on medical criteria.

5.0 Goals and Strategies

The goals and strategies for VIHA to the year 2007 are consistent with the overall goals established for the health system in the Ministry of Health Services/Planning Service Plan. The actions, which will be undertaken to achieve the goals and strategies, are outlined in the Redesign and Budget Management Plans, which are included in Appendix B.

Performance measures and targets are included in Appendix C. In some cases targets are not yet included as they are currently under development. The side bar provides a summary of the goals and strategies provided in more detail over the next pages.

Goal 1: Improved Health And Wellness Of VIHA Residents

Working with community partners to support residents of VIHA in their pursuit for better health through protection, promotion and prevention activities.

The health and wellness of individuals is determined by a number of factors, including: biology and genetic endowment, the physical environment, living and working conditions, personal health practices and coping skills, and health services. With the exception of health services, these determinants are largely out of the control of the health authority. It is not reasonable to expect VIHA to be held solely accountable for the health status of its residents. However, it is reasonable to expect VIHA to assume some responsibility for addressing the broad determinants of health through advocacy, coalition building, partnership development, community development and research. The challenge for VIHA is to target efforts to priority areas where there is a clear need, and an ability to influence health.

Strategies:

1. **Working with community partners, such as education, social services, and housing to support residents of VIHA to make healthy lifestyle choices.**
   Prevention and promotion activities will be targeted to support residents of VIHA make positive lifestyle choices. Healthy lifestyle choices, such as not smoking, healthy eating and exercise can reduce the burden of disease, disability and injury.

Goals and Strategies

Goal 1: Improve Health and Wellness for VIHA residents
Strategies: Work with community partners to:
1. *Support residents of VIHA to make healthy lifestyle choices.*
2. *Implement core illness prevention and health protection programs.*
3. *Focus on specific populations where there is a clear need and ability to influence health.*

Goal 2: Ensure Quality, Client Centered Care and Service
Strategy:
4. *Redesign service delivery where appropriate to integrate health services across programs and by health service delivery areas.*

Goal 3: Create a sustainable, affordable public health system
Strategies:
5. *Create a work environment that attracts and retains talented people.*
6. *Develop and maintain effective partnerships with government and community agencies.*
7. *Review and update business models to support the strategic direction of the organization.*
8. *Manage the delivery of services within the funding provided from the Ministry of Health Services and other sources.*

2. **Prevent disease, injury or disability by working with community partners to implement core health prevention and protection programs.**
   There are many diseases, injuries and disabilities that contribute to poor health and premature death that are preventable. Core prevention and protection programs will be implemented targeting families with babies and children, school age children and youth and adults. As well VIHA will focus on environmental health programs, advocacy for health public policy and integrating prevention into chronic disease management strategies.

3. **Working with community partners to focus on specific populations where there is a clear need and an ability to influence health.**
   The VIHA population priorities include children and youth, frail elderly, aboriginal peoples, chronically ill, adults and seniors with mental illnesses and addictions, the downtown/hard to serve, persons with disabilities, and rural and remote populations. A more detailed description of each of these population priorities is included in Appendix D.

Goal 2: Quality Client-Centred Care And Service

Clients of VIHA will receive the right care and service, in the right setting, by the right provider, at the right time.

The goal is to focus the care and service on the client and their needs, as opposed to service providers. This requires health services to be planned, managed and delivered around the client.

Strategies:

4. **System redesign towards integrated delivery of health services across programs and by health service delivery areas (where appropriate).**
   Effective linkages need to be created among the health service sectors to create an integrated network of services that allows the patient/client to move more easily between various health settings and providers.
   - Enhance client and patient focus throughout the service delivery system.
   - Utilize and manage acute care services effectively.
   - Establish an accessible, high quality and sustainable surgical network.
   - Develop a long-term plan for an integrated comprehensive primary health care system.
   - Redesign continuing care services to include a range of community health services and supportive living options.
   - Redesign Mental Health and Addictions Services to augment appropriate community and residential care options.

Goal 3: A Sustainable, Affordable Public Health System

Care and services will be planned and delivered in a manner that will be sustainable in terms of human, capital and financial resources required.

Service capacity will be planned in a realistic manner, based on the population and their health needs. Service delivery will be efficient, sustainable and affordable, meeting the expectations, which have been established for the health authority by the Board of Governors and the Ministry of Health.

Strategies:

5. **Create a leading health services work environment to attract and retain talented people throughout the health authority.**

6. **Develop and maintain effective partnerships with government and community agencies.**

7. **Review and update business models to support the strategic directions of the organization.**

8. **Manage the delivery of services within the funding provided from the Ministry of Health and other sources.**

6.0 Planning for Future Service Delivery

"..The world will not evolve past its current state of crisis by using the same thinking that created the situation."
- Albert Einstein

History tells us that service delivery in the future will look vastly different than service delivery today. Planning based on a straight line projection of the acute utilization rates prevalent in the early 1980s would have "over built" the contemporary system with at least twice the current bed capacity.

It is important to look beyond the way services have always been delivered. The aging baby boomers will push current service delivery models, demanding options and choices. Along with the changing consumer profile and expectations, there will continue to be significant advancements in treatments and drugs, improved information technology, refined scope of practice of health professionals, continued pressure to achieve fiscal and program sustainability, and increased accountability.

Canadian Health Care Trends
Recurrent themes which are emerging for a sustainable health care system include:

- *Emphasize Population Health*
- *Improve Quality, Safety and Access*
- *Refine Regional Structure*
- *Expand Public Insurance Coverage*
- *Achieve Fiscal Sustainability*
- *Increase Accountability and Local Involvement*
- *Improve Coordination and Supply of Human Resources*
- *Re-organize Primary Care*
- *Better Use of Technology and Innovation*
- *Maintain the Canada Health Act*

Ministry of Health Planning 2003

Future planning in VIHA is directed towards an integrated service delivery model and is proceeding in a systematic way. The remainder of this document addresses VIHA's service delivery direction, with a focus on the:

- *Strategic Direction Within Sectors* - with specific consideration to the flow of clients through the system. Bottlenecks in the system exist largely at the point where a client moves from one service to another, such as: from hospital to residential care or from community to hospital.

  The future need for services will be projected based on the demographics, health needs and anticipated changes in delivery of health services. The projection of service capacity in VIHA is proceeding in the areas where data is available, such as acute care, complex care, assisted living and home care (direct care and home support). This data will be analyzed in an integrated manner assessing the need for services on a community basis. These projections will be incorporated into the 2004/05 Redesign and Budget Management Plans.

- *Infrastructure Requirements* - to support the strategic direction of the organization. Initial enabling plans have been developed in the following areas: human resources, physician resources, information systems, business development, quality improvement, strategic communications and capital. These plans are at various stages of development and will continue to be updated on a regular basis. Two additional enabling plans will be incorporated into the overall Plan in the future - research and education, and organization design.

7.0 Strategic Direction By Sector

National and Provincial Trends...

For the past decade, the in-patient hospital sector has been shrinking. Fewer patients are admitted to hospital each year and those who are admitted stay for a shorter period of time. In the past five years, the Canadian Institute for Health Information (CIHI) has reported that more than 275 hospitals across Canada have closed, merged, or been converted to other types of facilities (CIHI 2001). These changes are attributable to technological advances, changes in practice with a focus on minimum lengths of stay and a shift to ambulatory services where possible, and budget constraints.

In comparison with the rest of the country, B.C. has one of the lowest hospital utilization rates. In 1999-2000, B.C. was third lowest when compared to other provinces.

VIHA will plan, manage and deliver a range of coordinated, integrated and sustainable services that focus on the needs of clients in all health care sectors. That means ensuring appropriate and efficient use of acute care and rehabilitation services, providing a range of options in home and community care services, targeting resources to the mentally ill, improving primary health care delivery (especially to the chronically ill), and supporting public health and prevention initiatives.

Acute Care and Rehabilitation

Acute care refers to the level of care in which a patient is treated for a brief but severe episode of illness for conditions that might result from disease, trauma or surgery. Rehabilitation is the process of enabling an individual to reach an optimum mental, physical and social functional level. Acute and rehabilitation care is provided in hospitals, community health and access centres, outpost stations and at home.

There is variation in the type of care, which is provided across facilities in the health authority, ranging from basic primary health care to complex surgery. (A summary of the VIHA facilities and key statistics is provided in Appendix E).

VIHA Trend:

- In 2002/03, the VIHA weighted case rate[1] for acute and rehabilitation was 124.7 per 1,000 population. This rate is higher than the provincial average of 120.5.
- Within VIHA, hospital utilization varies significantly. It is lowest in the South (weighted case rate of 120), slightly higher in the Central area (weighted case rate of 123), and highest in the North (weighted case rate of 145).
- The use of hospital services varies significantly among communities within VIHA, with residents of some communities being admitted to hospital more than twice as often as others.
- People with similar conditions stay in hospitals for different lengths of time.
- About 12% (190) of hospital beds are currently filled with individuals who no longer require acute care. Currently, seniors make up 10% of the VIHA population, but they account for about 33% of the admissions and 50% of the patient days.
- The VIHA population receives 94% of its hospital care within the authority.

[1] Weighted Case Rate is a relative measure of expected resource use.

Future Acute Care and Rehabilitation Service Delivery

Planning for hospital services involves determining the optimum number, type and location of hospitals and health centres throughout the health authority. This will facilitate future operational decisions with respect to service delivery as well as capital investments.

Initial analysis projecting the number of patients that will use acute services to the year 2007 has been undertaken and is in the process of being refined. The analysis incorporates future population growth and assumptions with respect to future utilization and Alternate Level of Care (ALC) patients. Projections will be analyzed in an integrated manner with the planning that is underway in Home and Community Care, assessing the overall community impact. Key considerations in defining the future acute service delivery system are quality, access, and sustainability.

Quality

Quality care has been defined as patients receiving the right care at the right time by the right provider in the right setting. Health Services will be planned, managed and delivered around the client. There are a number of quality initiatives planned and underway that will improve future service delivery:

Acute Care Networks - Networks are currently being developed in the areas of critical care services, emergency health services, and surgical services. Future networks will be developed or enhanced in areas such as medical services, cancer services and child and family services. The goal of each network is integrated strategic planning and coordinated management of services to ultimately provide better care for those we serve.

Clinical Pathways - Clinical pathways will be developed in areas where there are opportunities for improvement in patient outcomes through collaborative service delivery strategies. Current initiatives underway include trauma and stroke care. There will be a specific clinical focus to facilitate timely, coordinated and effective change management.

Access

VIHA's planning for hospital services is taking place within provincial standards that ensure all residents have reasonable access to acute care service no matter where they live. These standards are based on time of travel and population size. They were developed to make certain the rationalization of hospital services occurs within a reasonable framework and in particular to ensure residents of rural areas are assured accessibility to acute services. Any changes that VIHA makes in the delivery of acute services will recognize these standards.

Provincial Access Standards for Acute Care:

Emergency Services – access to emergency services on a 24/7/52 basis must be available within a one-hour travel time for 98% of residents within the health authority and for 95% of residents within the Health Service Delivery Areas (HSDA). Emergency services include: outpost stations, community health access centres, hospitals, and group practices.

Acute In-patient Services – Access to basic in-patient hospital services must be available within two hours travel time for 98% of the population of each HSDA.

Specialty Services – Core specialty services must be available within four hours travel time for 98% of residents within the region and 95% of the population of each HSDA.

Sustainability

Sustainability is defined in terms of the ability to deliver affordable services in an appropriate manner consistently over time. As VIHA plans the future distribution of hospital resources, consideration must be given to the projected impact on facilities of various sizes. Consideration will also be given to the sustainability of a specialty service. The recruitment and retention of specialists and other professional staff is key to maintaining specialty services. A critical mass of population is needed to ensure that specialists perform a minimum number of procedures to maintain their clinical skill sets.

For a hospital to provide specialty services at a sustainable level, it must also support a group of specialists that can maintain a reasonable on-call schedule. Core specialty services must be available at all times and new services cannot be implemented without an appropriate long-term financial commitment. VIHA will continue to meet all provincial standards for accessibility for specialty services.

There are approximately 900 general practitioners (GPs) working in VIHA. The highest doctor to population ratio is in Victoria and the lowest is in Vancouver Island West, Lake Cowichan, Sooke and Port Alberni. There are currently 600 specialists practicing in VIHA. A range of 3 to 5 physicians is required for continuous coverage (24 hours per day, 7 days per week). Victoria and Nanaimo are the only areas that currently maintain 5 physicians in each of the core specialties.

National and Provincial Trends...

In 2002/03, the residential bed rate in B.C was 96.1 beds per 1,000 population aged 75+. This rate is:

- *slightly below the Canadian average (99.8 beds/1,000 population aged 75+);*
- *third lowest, in comparison with other provinces – lower rates occurred in Ontario (89.3), New Brunswick (90.1), and Nova Scotia;*
- *high relative to other countries (European countries report 33% to 50% lower residential care use than Canada. For instance, Sweden has only 3.1% of their senior aged 65+ living in residential care, compared to 6.1% in B.C.) (Home and Community Care Division, Ministry of Health Services 2003)*

Within B.C., the rate varies significantly across health authorities, ranging from 83.7 beds per 1,000 residents 75+ in VIHA to 120.5 in the Northern Health Authority. A summary of residential care rate by health authority and HSDA is included in Appendix D.

Home and Community Care

Home and Community Care includes a range of services:

- Residential Care: Facility based professional care provided 24 hours a day, 7 days a week for conditions that are medically unstable and/or need a professional response on an unscheduled basis.
- Assisted Living: Support services and personal care are provided to those individuals who wish to and are able to live with maximum personal responsibility in a housing environment but who require support to do so.
- Home Support: Assistance with personal care, and activities of daily living provided in home by visiting non-professional care aides.
- Home Care Nursing: Nursing support for people with chronic and/or complex health needs or following an acute illness.
- Palliative Care: Physical care, social, emotional and spiritual support to patients and their families through various stages of advanced illness. Support is provided to clients and their families to remain in their homes for as long as is reasonable and desirable.
- Rehabilitation: Physiotherapy and occupational therapy provided to alleviate the effects of acute illness, chronic or complex health needs.
- Community Nutrition: a range of clinical nutrition services.

Home and community care services are currently undergoing a significant shift from a reliance on facility care to a system that promotes independence in the community. The range and types of services are expanding to include more supportive living arrangements.

VIHA Trend

- Over the past five years, the number of clients admitted to residential care who require complex care services has increased (the proportion of heavy care clients in residential care has increased from 74% to 83%).
- Over this same time period, home support hours decreased by 10% and the number of clients decreased by 18%. The decrease was mainly in lighter care, which is attributable to a change in eligibility policy for home support services.
- Within VIHA in 2002/03:
  - residential care beds per 1,000 population ranged from 74.9 in the Central area to 89.5 in the South (See Appendix F);
  - home support hours per 1,000 population ranged from 1517 in the Central area to 2538 in the South; and
  - direct care visits per 1,000 population ranged from 215 in the South to 257 in the North.

Future Home and Community Care Service Delivery

A number of provincial initiatives will influence the future direction of home and community care in VIHA including:

New Access Policy – A new provincial policy has been implemented that results in only those with complex needs being admitted to facility settings. All others are expected to be served by various community programs. This has rendered a large proportion of existing residential care beds unsuitable for the new higher needs population because of design and building limitations or insufficient staffing budgets.

Provincial Planning Model – A planning model has been established provincially for health authorities, which is based on the 5000 net new space target for long term care.

Projected Increase in Home Support Utilization – The emphasis on facility care for only complex needs and the shift to community care will require increased home support resources for clients with higher needs living in the community.

Introduction of Independent Living – assisted living units with support services established throughout the province.

Within VIHA, Home and Community Care services are being redesigned towards a system that promotes independence and self-care through an increased range of community alternatives.

VIHA's overall goals for redesign are to:

- assist individuals to live in the community as long as they are able and wish to do so;
- provide high quality complex facility care for those who require it in a homelike environment that respects privacy, dignity and choice;
- enhance client choice and reduce reliance on acute care resources by offering a network of care options to support independence, including assisted living; and
- develop community capacity by partnering with housing and community groups to improve their ability to support individuals who need assistance.

The home and community care redesign is comprised of a highly interwoven series of steps that involve the closure of residential care beds and the re-investment of dollars into respite care, a variety of adult day programs, community bathing, assisted living, and complex facility care.

Analysis is currently underway to project the future needs for home and community care services. Projections will incorporate future population forecasts, health needs and anticipated changes in service delivery. Once this analysis is complete, community impact will be assessed in an integrated manner with consideration to other service delivery changes. The intent is to ensure coordinated service for clients as they are discharged from hospital to communities, or move from one level of care to another.

National and Provincial Trends...

Mental illness is one of the largest contributors to disability. The onset of most mental illnesses occurs during adolescence and young adulthood, and affects people of all ages, educational and income levels, and cultures.

Twenty percent of Canadians will personally experience a mental illness during their lifetime.

Of the ten leading causes of disability worldwide, five are mental disorders (major depression, schizophrenia, bipolar disorder, alcohol use disorder and obsessive compulsive disorder). The burden of illness caused by mental illness is expected to increase within the next two decades, with depressive illnesses becoming the leading cause of disease burden in developed countries. (Health Canada 2002)

Mental Health and Addiction Services

VIHA mental health and addiction services are designed to serve people with mental illnesses and/or substance misuse problems. Approximately 50% of people who suffer from mental illness have concurrent substance misuse problems.

Mental health and addiction services are delivered in a variety of settings: residential care facilities, group homes, community clinics, day hospital, acute care, community outreach and community centres. These services vary by community but generally include: access and emergency response, acute treatment and detox, residential facilities and tertiary care, including supportive recovery, community treatment, rehabilitation and recovery services and psychogeriatric services.

VIHA Trend

- VIHA's utilization rate for mental health is the highest in the province at 15.3 weighted cases per 1,000 population (provincial rate is 11.4).
- Twenty-one percent (21%) of the days spent in hospital in VIHA by patients with mental health diagnosis are after the need for hospital care has ended. This has increased gradually over the past six years. The target set out in the Ministry/VIHA Performance Agreement is to decrease the Alternative Level of Care days for mental health clients by 2% for each of the next two years.
- Although the seniors population aged 70 and over represents only 21% of mental health/addictions cases in acute care, they use 43% of the overall days because their stays are longer.
- Community follow-up in a timely manner after an in-patient stay is very important for treatment of mental health clients. In 2001/02, 60% of clients received community follow-up within 30 days of an in-patient stay. Targets have been established in the Performance Agreement to increase this by 3% over each of the next two years. The data to track community follow-up is not currently available within VIHA.

Future Mental Health and Addictions Service Delivery

Key to the renewal of mental health and addiction services in VIHA is the strengthening of community capacity to allow clients to live as successfully and as independently as possible in their home communities. VIHA is taking the following actions to improve access to needed services for those with mental health and addictions issues:

Integrated, Community-Based Treatment and Services

In April 2002, responsibility for publicly funded addictions services was transferred from the Ministry of Health Services to health authorities. This has allowed VIHA to design an integrated system of care for people with mental health and addictions problems.

Improved Access

Clients are currently entering the health care system at multiple points. A coordinated process for accessing services will be implemented by the spring of 2004.

Expanded Services

Throughout 2003/04, community based mental health and addiction services are being expanded across VIHA, according to need:

- North Island will see a crisis network, housing, a mobile clinic and more rehabilitation;
- Central Island will establish transitional, emergency and residential housing. Planning is underway for 33 beds for those requiring 24-hour care; and
- South Island will offer housing and respite services.

Improved Communication and Information Systems (Island Wide)

Significant work is currently underway to develop information systems to support integrated care and monitor services.

Design and Development of Psychiatric Emergency Service

Emergency services for people with significant psychiatric crisis to be implemented in fall of 2004, adjacent to the Royal Jubilee Hospital Emergency Room.

Riverview Replacement

A provincial initiative is moving residents from the Riverview facility (part of the Provincial Health Services Authority) back to their home regions, while adding acute care and community capacity to VIHA to help receive them.

VIHA's mental health renewal initiatives include an innovative range of community services that have not been available in the past. Limitations in data and information systems make it difficult to analyze current service delivery in a systemic manner and to project future need. However, the implementation and evaluation of these initiatives will provide the data necessary to allow VIHA to better project the service capacity and need in this sector for the future.

National and Provincial Trends...

Federal and Provincial Governments are committed to the notion that improvements to primary health care are crucial to the renewal of health services. The province is nearly two years into the four year federally funded Primary Health Care Transition Fund (PHCTF).

Over the past thirty years, there have been many plans and proposals to improve primary health care in Canada. It is clear that progress in primary health care reform is not due to a lack of vision, goals, plans or innovative ideas (Hutchinson 2001).

B.C. is developing a provincial strategy for primary care renewal. Components to be included in the strategy include: structure and organization of services, quality of day-to- day primary health care services, remuneration models and fee schedules, scope of practice for health professionals, access to specialty services and information technology.

Primary Health Care and Chronic Disease Management

Primary Health Care encompasses the first contact a person makes with the health system, whether at a physician's office, health clinic, community health centre or hospital. In many ways, primary health care is the glue that holds the many components of the system together for the client. Improved primary health care will help to ensure that client care and service is coordinated and proactive. It will increase the range of services and expand client choices, particularly in small towns and rural areas.

Improving primary health care involves setting up different models of care so that clients might, for instance, access multidisciplinary teams of health service professionals, such as a family physician, a dietician, a mental health counselor and a physiotherapist all in the same clinic – thus ensuring the right health care professional meets the needs of clients. Other models include networks of physicians, shared care between family doctors and specialists and augmented roles for nurses. Improving the effectiveness of primary health care will involve matching the appropriate model to meet those needs.

A key focus of primary health care reform is to coordinate care for chronic diseases. These are long-term and life threatening illnesses that have a profound effect on the physical, emotional and mental well-being of individuals. They include illnesses such as diabetes, hypertension, congestive heart failure, asthma, depression, and renal failure. Enhanced primary health care could result in improved long-term management of an illness, with an emphasis on individuals maintaining independence and keeping as healthy as possible through prevention, early detection, and effective case management.

VIHA's Primary Health Care Initiatives

A number of primary health care initiatives are now underway in VIHA, funded through the Primary Health Care Transition Fund:

- South Island Chronic Disease Management Network – focus on clients with chronic disease in Greater Victoria;
- Chronic Kidney Disease Care – focus on clients with chronic kidney disease throughout VIHA - in partnership with the Provincial Health Services Authority;
- Aberdeen Primary Health Care Project – multidisciplinary care for adults (55+) and their caregivers;
- Ladysmith Primary Health Care Project – establishes a primary health care organization supported by multidisciplinary teams;
- Mount Waddington Primary Health Care Renewal – focus on chronic disease, mental health, alcohol and drug addictions, youth and young adult sexual health and pregnancy;
- Advanced Directives in Primary Health Care (VIHA-wide).

Future Primary Health Care Service Delivery

A key component to the future of health services in VIHA is the development of a comprehensive and integrated primary health care system. A strategic plan for Primary Health Care is currently being developed. This will address future initiatives and integrate all components of primary health care into a service delivery system that better meets the needs of the population and health professionals.

National and Provincial Trends...

Common themes in all of the recent Canadian and provincial reports include the need to:

- *shift the focus from treating to preventing illness;*
- *establish a better balance between prevention and treatment;*
- *integrate more interventions aimed at reducing health risks and enhancing quality of life by addressing the broader determinants of health;*
- *adopt healthy public policy and foster inter-sectoral collaborations; and*
- *address socio-economic disparities as a broad determinant of health, with particular attention placed on child poverty.*

Public Health and Prevention

VIHA is working closely with community partners to help residents reduce preventable conditions that lead to poor health and premature death.

Public health and prevention initiatives have played a key role in reducing the burden of disease, disability and injury. They have made major contributions to the health status of individuals and populations as a whole through basic community supports: outreach prevention, early intervention programs, and environmental health programs that target such issues as food safety, clean air, water quality, and communicable disease.

Prevention services in VIHA are targeted to:

- Families with babies and children - prenatal teaching, supports to parents, immunization, hearing screening, assessment and early intervention services, speech language assessment and treatment for pre-school children, pregnancy out-reach for expectant mothers at risk, postpartum depression supports, and investigation and follow-up of reportable communicable diseases.
- School age children and youth - health education, dental screening, youth health service, immunization, and follow-up on communicable diseases.
- Adults - community health advocacy including food security, immunization for diseases encountered when traveling abroad and for influenza, communicable disease surveillance, hearing assessment for Ministry of Human Resource clients.

Environmental Health Programs include community-wide health protection services to ensure public health and safety by minimizing environmental risks. Services include:

- food safety inspections;
- land use and sewage permits;
- clean air by-law enforcement;
- environmental impact;
- water quality surveillance:
- communicable disease surveillance; and
- licensing and inspection of community care and child care facilities.

Future Public Health and Prevention

There are many categories of disease, injuries and disabilities that contribute to poor health and premature death, which are preventable. VIHA is working with a variety of community partners to promote healthy lifestyle choices such as not smoking, healthy eating, and exercise. Specific initiatives include partnerships with the Traffic Safety Commission and sexually exploited youth.

VIHA is also involved in the Early Child Development Mapping Project, which will identify children who are less ready for school than other children – intellectually, socially, emotionally and physically. Data was collected in schools throughout VIHA in February 2003. Over the next few years, results will be used to help us better understand the factors impacting child development and provide the basis to create effective community-based responses that support the needs of children and families in their communities.

Other initiatives include support for regionally managed integrated tobacco enforcement and education programs, advocacy for health public policy (such as the move toward island-wide tobacco control by-laws), integrating prevention into chronic disease management strategies and meeting core service requirements.

8.0 Infrastructure Support

VIHA has developed a number of initial "enabling plans" to support the strategic direction it is taking throughout its health service delivery system. Many failures in major organization transitions are attributable to the lack of success in changing the old structures and processes (Bridges 2003). VIHA is targeting support areas in human resources, physician resources, information systems, business development, quality improvement, strategic communications and capital. Effective enabling plans will improve VIHA's ability to achieve an integrated health care system to meet client needs.

For example:

- information technology is required to support an integrated service delivery model. Technology solutions will create effective linkages among health services sectors, supporting an integrated network of information and tools that allow the patient/client to move among care settings and providers easily;
- future staffing needs will be anticipated based on demographics, attrition and changing service delivery models;
- physician resource planning will support the strategic direction for acute care. For instance, specialists will only be recruited where there is a critical mass and the service is sustainable;
- capital funding is limited and in high demand. It is essential that the decisions with respect to facility and equipment needs support the strategic direction;
- an integrated system of quality improvement which establishes and monitors outcomes and targets to change practice or behaviour is essential;
- business development opportunities provide potential revenue, which can be focused on initiatives such as information technology and capital; and
- strategic communications allow targeted messaging to specific audiences.

VIHA's enabling plans are at various stages of development and will continue to be updated on a regular basis. Future enabling plans to be incorporated include research and education, and organization design.

9.0 Next Steps

The Integration Plan will be reviewed and updated on an annual basis. The five year perspective will support the development of the Annual Redesign and Budget Management Plans which are submitted to the Ministry of Health. This Integration Plan 2007 provides a foundation for more detailed planning at the service and population levels.

Some of the next steps in the planning process include:

Redesign and Budget Management Plans

- Develop the Redesign and Budget Management Plans for 2004/05 to 2006/07, which will be informed by the strategic context outlined in the Integration Plan.

Scenario Planning

- The strategic planning process within VIHA will be advanced through scenario planning, which is a disciplined method for imaging possible futures for an organization. Scenario planning allows an organization to consider a whole range of possibilities in significant detail.

Forecasting Service Capacity

- Finalize projections for service capacity needs for acute care, residential care, and home care. Analyse projected service capacity on a community basis, considering the impact of a change in one sector on another, such as: the impact of a change in acute care on home care.

Refinement of Performance Measures and Targets

- Performance measures and targets will be continually reviewed, refined and updated.

Update of Population and Service Utilization Analysis

- Updated population and service utilization analysis.

Enabling Plan Updates

- Update all of the current infrastructure plans and develop new ones for organization design and research and education.

Update Integration Plan 2009

- Revisit and update plan during 2004/05.
- Incorporate service capacity planning at the community level.

APPENDIX A

VIHA POPULATION AND ABORIGINAL HEALTH STATUS STATISTICS

Population 2002 and 2007 for BC, VIHA, HSDA and LHA (P.E.O.P.L.E. 28)

LHA		Under 1 -19		20-64		65-74		75-84		85-90+		Total	
		2002	2007	2002	2007	2002	2007	2002	2007	2002	2007	2002	2007
61	Greater Victoria	38,888	37,018	132,527	136,675	15,684	16,122	15,309	14,089	6,861	7,206	209,269	211,110
62	Sooke	15,170	14,521	34,642	38,046	3,053	3,825	1,934	2,027	518	685	55,317	59,104
63	Saanich	13,028	11,417	35,109	36,868	6,202	6,387	5,509	5,688	1,633	2,432	61,481	62,792
64	Gulf Islands	2,688	2,510	8,493	8,805	1,786	1,985	1,189	1,261	362	558	14,518	15,119
41	**SOUTH**	**69,774**	**65,466**	**210,771**	**220,394**	**26,725**	**28,319**	**23,941**	**23,065**	**9,374**	**10,881**	**340,585**	**348,125**
65	Cowichan	13,850	12,291	30,245	31,742	4,583	4,618	3,067	3,300	857	1,308	52,602	53,259
66	Lake Cowichan	1,679	1,522	3,698	3,869	534	548	262	388	71	122	6,244	6,449
67	Ladysmith	3,857	3,585	9,450	10,081	1,651	1,692	1,202	1,353	319	490	16,479	17,201
68	Nanaimo	22,268	21,228	56,399	61,096	7,961	8,355	5,559	5,858	1,702	2,438	93,889	98,975
69	Qualicum	7,943	7,563	21,534	23,348	5,863	6,281	3,831	4,578	944	1,547	40,115	43,317
70	Alberni	8,113	7,100	19,160	19,222	2,457	2,642	1,495	1,615	437	644	31,662	31,223
42	**CENTRAL**	**57,710**	**53,289**	**140,486**	**149,358**	**23,049**	**24,136**	**15,416**	**17,092**	**4,330**	**6,549**	**240,991**	**250,424**
71	Courtenay	14,551	12,899	34,448	36,598	5,221	5,658	3,115	3,422	917	1,218	58,252	59,795
72	Campbell River	10,590	9,201	24,790	26,061	2,490	2,931	1,441	1,590	424	615	39,735	40,398
84	VI West	741	602	1,564	1,505	123	202	29	41	6	10	2,463	2,360
85	VI North	4,180	3,798	8,904	9,314	558	787	223	260	51	53	13,916	14,212
43	**NORTH**	**30,062**	**26,500**	**69,706**	**73,478**	**8,392**	**9,578**	**4,808**	**5,313**	**1,398**	**1,896**	**114,366**	**116,765**
	VIHA	**157,546**	**145,255**	**420,963**	**443,230**	**58,166**	**62,033**	**44,165**	**45,470**	**15,102**	**19,326**	**695,942**	**715,314**
	BC	**994,243**	**954,620**	**2,595,209**	**2,806,579**	**290,384**	**315,693**	**195,643**	**213,334**	**66,793**	**88,520**	**4,141,272**	**4,378,746**

Aboriginal Health Indicators: Status Indians (SI) and Other Residents

Region[2]	Infant Mortality Rate (1991-1999)			Potential Years of Life Lost (1991-1999)			Age Standardized Mortality Rate (1991-1999)			Teen Pregnancy Rate (1999)			Low Birth Weight (1991-1999)		
	SI	Other	Ratio: SI/ Other	SI	Other	Ratio: SI/ Other	SI	Other	Ratio: SI/ Other	SI	Other	Ratio: SI/ Other	SI	Other	Ratio: SI/ Other
South Vancouver Island	12.8	4.4	2.9	152.1	49.2	3.1	126.3	60.7	2.1	117.5	40.2	2.9	6.1%	4.8%	1.3
Central Vancouver Island	17.0	4.6	3.7	144.3	55.5	2.6	94.0	62.0	1.5	154.0	40.3	3.8	5.8%	4.5%	1.3
North Vancouver Island	18.5	5.2	3.6	142.9	57.8	2.5	110.3	65.0	1.7	144.4	40.9	3.5	6.0%	4.8%	1.3
BC	10.6	4.9	2.2	142.3	53.6	2.7	103.3	61.8	1.7	131.2	35.1	3.7	5.6%	5.0%	1.1

Note: The ratio reflects how many times higher the Status Indian rate is compared to the Other Residents rate

Region	Life Expectancy 1995-1999								
	Male			Female			Total		
	SI	Other	Difference in Years: SI-Other	SI	Other	Difference in Years: SI-Other	SI	Other	Difference in Years: SI-Other
South Vancouver Island	67.3	78.0	10.7	74.7	81.8	7.1	71.2	80.0	8.8
Central Vancouver Island	70.8	77.1	6.3	74.0	81.5	7.5	72.5	79.2	6.7
North Vancouver Island	67.7	76.8	9.1	75.1	80.8	5.7	71.5	78.7	7.2
BC	69.3	77.2	7.9	75.0	81.7	6.7	72.1	79.5	7.4

Source: Provincial Health Officers Annual Report 2001 "The Health and Well-being of Aboriginal People in BC"

[2] The rates are from the former regions, Capital, Central Vancouver Island, and Upper Island/Central Coast-The boundaries of these former regions are reflective of the current boundaries with the exception of the inclusion of LHA 83 in the Upper Island/Central Coast

APPENDIX B
VIHA REDESIGN AND BUDGET MANAGEMENT PLAN
2004/05 - 06/07

Edited July 2004

VIHA Redesign and Budget Management Plan
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1.0 INTRODUCTION

There is much being done within VIHA to further the goals and objectives articulated within the Integration Plan. This document focuses primarily on specific initiatives VIHA will implement in 04/05 to cope with the financial pressures it faces and to move its strategic agenda forward. The following is a summary of the initiatives included in this document:

Clinical Support Process Improvements and Utilization Management	**Process improvement initiatives to result in savings and efficiencies in diagnostic testing and pharmacy.**
Consolidation and Restructuring of Lab Services	Continuing actions to consolidate lab services reduce supply costs.
Professional Staff Mix	An initiative intended to reduce inconsistencies in the mix of licensed and unlicensed care providers while maintaining a high quality of care.
Restructuring Acute Services	Continued restructuring of services in North, Central and South service delivery areas to meet high priority service needs and continuing focus on appropriate utilization of acute services.
Restructuring Home and Community Care	A broad reaching plan to make investments in home and community care services to promote independence and self-care. Also included is a specific initiative to review home support services to Mental Health clients. These investments will help to enable changes in acute care services.
Mental Health Facility Service Redesign	An initiative to review the community care facility resources supporting mental health clients.
Corporate Initiatives	A variety of initiatives that began in prior years to increase revenues from out-of-country patients, non-contract staff vacancy management, closure of the Gorge Road Hospital and contracting out support services.

In addition to these initiatives, VIHA will strive to implement measured steps to enhance services for targeted populations at risk and to improve the effectiveness and sustainability of the Region's overall health service delivery network. Special efforts will be made to insulate some parts of VIHA's service delivery organization from the serious cost pressures to be surmounted in this fiscal year. For example, new and expanded services will continue to be implemented for mental health, addictions and downtown hard-to-serve populations. New service delivery alliances and models continue to be pursued for aboriginal populations. Population Health and Prevention services will be strengthened in recognition of their important work in health protection.

A more comprehensive service delivery plan that captures all of these components will be developed during this fiscal year as the Integration Planning process progresses.

2.0 BUDGET MANAGEMENT PLAN SUMMARY

Health Authority: Vancouver Island
Budget Management Plan 2004/05 to 2006/07
Template 2 - Statement of Operations

($ millions)	Budget			
	2003/04	2004/05	2005/06	2006/07
REVENUE				
Contributions				
From the Province - MOHS (Regional)	1,001.013	996.397	999.353	1,002.667
From the Province - other than MOHS	8.367	8.367	8.367	8.367
From Health Authorities and Gov't Orgs	42.354	42.354	42.354	42.354
Federal Government	0.088	0.088	0.088	0.088
Other Contributions	1.880	1.880	1.880	1.880
MSP - Fee for Service	46.140	44.682	44.390	44.390
MSP - Sessional	10.282	10.282	10.282	10.282
Pharmacare	-	-	-	-
Co-payment and Room Differential	23.161	25.311	25.311	25.311
Fees and Licenses	14.963	14.963	14.963	14.963
Investments (non-sinking fund)	3.915	3.915	3.915	3.915
Amortized Revenue	3.793	3.793	3.793	3.793
Sales to Related Parties	-	-	-	-
All Other Revenue	25.944	25.944	25.944	25.944
Total Revenue	**1,181.900**	**1,177.976**	**1,180.640**	**1,183.954**
EXPENSE				
Compensation				
Salaries and Wages	578.559	543.751	534.854	525.898
Benefits	127.417	123.542	126.734	130.895
Purchased Services				
Physician	53.280	57.428	57.428	57.428
Other	6.023	6.156	6.285	6.417
Sub-total	765.280	730.876	725.301	720.638
Supplies	111.706	110.748	111.743	112.534
Sundry	32.790	43.052	43.956	44.879
Equipment	20.142	26.934	27.500	28.077
Referred out Services	247.390	252.553	267.323	272.882
Restructuring Costs	-	9.000	-	-
Buildings and Grounds	2.338	2.439	2.490	2.543
Total Expense	**1,179.646**	**1,175.602**	**1,178.313**	**1,181.553**
SURPLUS/(DEFICIT) BEFORE AMORTIZATION	**2.254**	**2.374**	**2.327**	**2.401**
Amort. of Deferred Capital Contributions	39.7	45.380	47.948	50.626
Write-Down of Capital Assets	0	-	-	-
Amortization of Capital Assets	(41.955)	(47.755)	(50.276)	(53.028)
Gain/(Loss) on sale of Capital Assets	0.001	0.001	0.001	0.001
SURPLUS/(DEFICIT) AFTER AMORTIZATION	**0.000**	**(0.000)**	**(0.000)**	**0.000**
St. Joseph's General Hospital	-	-	-	-
Mount St. Mary's Hospital	-	-	-	-
COMBINED SURPLUS/(DEFICIT)	**0.000**	**(0.000)**	**(0.000)**	**0.000**

Note: Health Authorities have the option of including their denominational affiliates in the body of the report or on a separate line at the bottom of the report. If listing on a separate line, each denominational affiliate should be labeled and shown on a separate line.

3.0 PROGRESS UPDATE FOR SAVINGS AND REVENUE INITIATIVES COMPLETE IN 03/04

The following initiatives were included in the 03/04 - 05/06 Health Service Redesign Plan but will not be part of the 04/05 Plan. The initiative may have been concluded in 03/04 or there is insufficient progress to anticipate significant savings or revenue for 04/05. A progress report on the remaining initiatives that are proceeding into 04/05 is included with the initiative description in the remaining sections of this document.

Initiative Title	03/04 Redesign Ref #	Progress Report
Pharmacy Drug Utilization - *Complete*	2.3	In 03/04 the West Coast General Hospital and Cowichan District Hospital physicians adopted the antibiotic utilization guidelines established in 2002 at Nanaimo Regional General Hospital (NRGH). A clinical pharmacist recruited to NRGH in 2003 followed a 10-month process to implement change. Monitoring of Central Island antibiotic utilization demonstrated that target savings were realized with the continued use of the implemented guidelines.
Paramedical Efficiencies - *Complete*	2.7	This initiative began in 02/03 and with the objective of rationalizing the number of paramedical professional (social work, therapists, psychologists etc) positions within VIHA given the reconfiguration of acute care services that was also occurring. A target reduction of 40 fte was set and substantially achieved. The financial savings in the 03/04 Redesign Plan was the annualized amount.
Surgical Booking Redesign *Continuing with no savings 04/05 target*	2.9	This initiative involved streamlining the booking and pre-admission processes at Royal Jubilee and Victoria General Hospitals. The booking nurses were redeployed and replaced with booking clerks and several policies and procedures were streamlined. Electronic operating room slate distribution within these hospitals is being investigated for further efficiencies.
Affiliate Overhead Cost Reduction - *Continuing with no 04/05 savings target*	3.3	Funding allocations provided to residential care facilities in 03/04 resulted in administrative savings being achieved by a number of facilities in that fiscal year. A review of VIHA's funding methodology for residential care facilities was undertaken during 03/04 to identify among other things, any further opportunities to achieve administrative and support savings. The review is still underway and a phased implementation plan is under development.
Hospital Based Revenue Generation - Category II *Discontinued*	5.3	The intent of this initiative was to increase revenue for services provided that are not covered by the Canada Health Act. VIHA will be exploring revenue potential from several specific items or procedures (e.g. ceramic hips), but will not be putting significant emphasis on these types of revenue overall in the future. The potential return on investment in unclear.
Retail Initiatives *Continuing with no 04/05 savings target*	5.4	Retail opportunities were reviewed at four acute care sites and a comprehensive retail strategy was developed for Nanaimo General, Victoria General and Royal Jubilee hospitals. Implementation plans are now under development. Facility renovation will likely be needed therefore no new net revenue is anticipated for 04/05.
Business Development **Continuing with no** *04/05 revenue target*	5.5	Previous plans to develop a consolidated vending agreement were delayed in 03/04 due to food services contracting out. A request for vending proposals will be issued in 04/05. Market research has been conducted for increased advertising opportunities and a request for information (RFI) was issued. RFI responses were received April 23. Decisions will be made regarding next steps once RFI responses have been reviewed.

Initiative Title	03/04 Redesign Ref #	Progress Report
		Programs were implemented at three hospital sites in 03/04 - (Campbell River, Nanaimo and Saanich Peninsula) to increase sales of hospital amenities such as private rooms, TV's and phones. The program involves packaging amenities to reduce the cost of individual items and thereby increasing sales. Results from all sites are promising.
Food Services Efficiencies *Complete*	5.7	This was the final year of a two year initiative to improve efficiencies within food services while contracting out discussions were underway. The focus for 03/04 was Central and North Island. Savings were realized through scheduling efficiencies and consolidation of food purchasing.
Compensation Management *Continuing with savings to be realized in select areas*	5.10	This plan involved putting supports in place to improve productivity through reductions in overtime, improved attendance, including relief to replace staff during absences (vacation, sick, etc.) and insurance premiums. While final year-end numbers are still being produced, the data available indicates that these targets are well on the way to being achieved. For example, overtime has continued to fall from 2.00% of Total Worked Hours in 2002/03 to 1.66% in 2003/04, representing a 17% reduction/savings and outpacing the 1.74% set by VIHA at the beginning of 2003/04. Similarly the staff injury rate has seen a 15% reduction from 2003/04. Paid sick leave is the only indicator that has not improved and is presently 3.3% higher than in 2002/03.

4.0 ACUTE CARE INITIATIVES 04/05

4.1 Clinical Support Process Improvements and Utilization Management

Description	Throughout VIHA, Clinical Support Services will be undertaking, or have completed a number of initiatives that will result in significant savings from reduced demand, lower costs and improved revenue capture. Service demands will be reduced as a result of Limited Activity Days in hospital and reduced bed capacity (see Acute Care 4.3, 4.4, 4.5). Plans are also in place to implement increased utilization management in diagnostic areas (e.g. appropriate use of troponins in the case of heart attack). These initiatives will result in savings for laboratory, medical imaging and pharmacy. Also planned are a number of process improvements to increase operating efficiencies. Pharmacy will be implementing an automated drug distribution system in 04/05 in the South Island.		
Progress Update	Savings have been realized with the introduction of a digital image storage system and installation of a high volume lab. Diagnostic angiography has been replaced by magnetic resonance angiography that can be done on an outpatient basis. In laboratory, over 20 Ministry and British Columbia Medical Association protocols have been adopted, while in the pharmacy restrictions have been put in place for activated protein C and other high cost drugs.		
Milestones for 04/05	▪ Automated (robotic) core lab at Royal Jubilee Hospital - Jun 03 ▪ Centralized Intravenous Admixture Production facility - Aug 04 ▪ Picture Archiving Communications System South - complete (except Lady Minto - tbd) ▪ PACS installation at Nanaimo Regional General Hospital - ongoing		
Measures	▪ Utilization rates for exams, tests and pharmaceuticals ▪ Implementation of lab ordering protocols and assessment of impact on utilization ▪ Estimated cost avoidance of repeated imaging exams		
Challenges to Implementation	None identified.		
Financial Implications	Total savings will be $1.54 million for 04/05. Minor capital investment in barcode readers to support picture archiving communication system in Radiology. Funding for laboratory equipment and medication delivery system is in place.		
03/04 Redesign Plan Reference	*2.1*	***Link to VIHA Goals***	*#3 Create a sustainable and affordable public health system.* *#2 Ensure quality, client centered care and service*

4.2 Consolidation and Restructuring of Lab Services

Description	This is an ongoing initiative first identified in 02/03. It involves consolidating lab services within VIHA, increasing testing capacity to optimize lab efficiencies and reduce the costs of reagents. For 04/05 in the Central Island microbiology will be centralized at Nanaimo Regional General Hospital and the Ladysmith District Hospital and Chemainus Health Care Center will be converted to "satellite" labs with Point of Care Testing (POCT) performed by nursing staff. This year a partnership will be developed with one or two of the major vendors for chemistry and hematology analytical equipment. These vendor discussions are already underway.		
Progress Update	Over the past two years lab restructuring increased access to outpatient services and improved service quality to physicians and patients. More lab testing and analysis is occurring within VIHA rather than the lower mainland resulting in decreased turnaround time for results and redirection of these revenues to VIHA. Access and quality indicators will continue to drive decisions regarding future consolidation of lab services.		
Milestones for 04/05	• Consolidation of Microbiology - complete • Establishment of satellite labs CI - Jun 04 • Impact review of prime vendor approach - Jun 04 • Organizational changes to facilitate regional standards - Aug 04 • Develop common guidelines to guide physicians on testing given clinical presentation - Nov 04		
Measures	• Turnaround times for referred out tests. • Quality Assurance programs are in place to measure accuracy and precision of POCT. • Client concerns		
Challenges to Implementation	The uncertainty surrounding the provinces' laboratory reform initiative will continue to have an impact on decisions within Regions.		
Financial Implications	Total savings for 04/05 will be $0.26 million.		
03/04 Redesign Plan Reference	*2.2*	***Link to VIHA Goals***	*#3 Create a sustainable and affordable public health system.* *#2 Ensure quality, client centered care and service*

4.3 Restructuring Acute – North

Description	This restructuring involves the continuation of a series of initiatives that began in 2002/03 to redesign acute services in the Mount Waddington and Comox/Strathcona areas. The objectives of the redesign have been to enhance community based services for aboriginal people, seniors and mentally ill adults and thereby reduce inappropriate utilization of hospital services. For 04/05 additional measures will be taken to redirect targeted hospital services to community care through enhanced primary care, aboriginal health services and assisted living. Efforts will also be focused upon examining appropriateness of acute care admissions and lengths of stay. A plan to improve maternity services in the Mount Waddington area will be implemented so that low risk deliveries can occur locally. Health service levels to several small communities will also be re-examined throughout the year as resource jobs are eliminated and the population in the area decrease.		
Progress Update	Over this past year a wide range of smaller measures have been taken to decrease sick time, improve efficiency of staffing rotations, reduce administrative support and increase hospital revenues through enhanced amenities. New drug technologies also helped to achieve necessary savings. Hours of operation for the Port Alice Health Center were reduced from 8 to 7 hours of nursing per day in keeping with demand.		
Milestones for 04/05	• Announcement regarding maternity services - Jun 04 • Implement Utilization Management to decrease length of stay and over census at Campbell River Hospital - Sep 04 • Implement overtime and sick time management plan - Sep 04 • Implement service adjustments as appropriate to evolving community populations		
Measures	• Overtime and sick time rates • Alternative Level of Care rates • May Not Require Hospitalization Rates • Actual Length of Stay to Expected Length of Stay • Budget variance		
Challenges to Implementation	• Difficulties in recruiting professional staff to rural areas.		
Financial Implications	Total savings for 04/05 will be $1.09 million. At this time there are no capital implications.		
03/04 Redesign Plan Reference	*2.4*	***Link to VIHA Goals***	*#3 Create a sustainable and affordable public health system.* *#2 Ensure quality, client centered care and service*

4.4 Restructuring Acute – Central

Description	Efforts that began in 2002/03 to reconfigure acute services in the Central Island, with strong linkages to the development of primary care and residential/assisted living, continue for 04/05. A focus on community services is intended to lessen demand for acute care services. In addition, efforts will focus upon appropriateness of admissions to hospital and length of stay. A host of smaller measures will be taken to fund cost pressures. Services will be scaled back during off peak summer hours when staff are not generally available. There will be limited activity days every ten weeks at each facility. Further reductions in use of overtime are planned. Efficiencies in purchasing operating rooms supplies and equipment will be achieved.		
Progress Update	During 03/04 eight acute care beds were transferred to residential care in Cowichan. Planned temporary closures for the operating rooms did not proceed due to service demands although nine beds were closed at West Coast General to complete renovations there. A host of smaller staffing measures and supplies cost reductions did proceed and enabled the programs to find savings that offset increasing costs.		
Milestones for 04/05	• Implement amalgamation of Community Oncology Center - Jul 04 • Complete appropriate and sustainable bed map changes for Central Island - Aug 04 • Implement plan for alignment of surgical sub-specialties - Sep 04		
Measures	• Wait times for surgeries (as compared to standard where exist) • Procedure volumes relative to funded volumes • Overtime and sick time rates • Alternative level of care rates • May not require hospitalization rates • Actual length of stay to expected length of stay • Client concerns • Budget variance		
Challenges to Implementation	Ongoing challenges responding to complex care needs of seniors population as the system transitions from acute to community care, and ensuring patients admitted to hospital truly need acute care.		
Financial Implications	Total savings target for 04/05 will be $2.97 million.		
03/04 Redesign Plan Reference	*2.6*	***Link to VIHA Goals***	*#3 Create a sustainable and affordable public health system.* *#2 Ensure quality, client centered care and service*

4.5 Restructuring Acute – South

Description	Efforts that began in 02/03 to restructure acute care services in the South Island will continue in 04/05 in concert with changes to services in the community and for seniors. The focus of the restructuring has been to optimize the use of acute care beds within the constraints of compromised physical facilities and resources. The specific actions that have or will be taken for 04/05 include the conversion of approximately 30 beds to more appropriate use. Savings will also be realized through improved contract pricing for home oxygen and reassessments of patients who no longer qualify for subsidized therapy island wide. A number of smaller measures will be taken to achieve the savings and revenue target and minimize the impact on patient care.		
Progress Update	Improvement made to the booking model has enabled an increased number of procedures to be done (first available physician and same day admit; guarantee re-admit). The number of angioplasties has increased from 1355 to 1464 over prior year and waitlists for electives procedures has dropped from 84.2 days to 47.0 days. Significant savings have also been realized from tendering of costly devices such as stents and pacemakers. The plans for medical and surgical units changed during 03/04 due to service pressures and capital improvement costs. Thirteen surgical short stay beds were closed and limited activity days were implemented for the OR's.		
Milestones for 04/05	• Bed closures in Heart Health and on Royal 2 - complete • Home Oxygen contract negotiations and review of patients - complete • Complete bed map revision - Oct 04 • Implementation of bed map - TBD		
Measures	• Wait times for surgeries (as compared to standard where exist) • Wait times in Emergency Rooms • Procedure volumes relative to funded volumes • Overtime and sick time rates • Alternative level of care rates • May not require hospitalization rates • Actual length of stay to expected length of stay • Client concerns • Budget variance		
Challenges to Implementation	Ongoing challenges responding to complex care needs of seniors population as the system provides more assisted living options in the community, and ensuring patients admitted to hospital truly need acute care.		
Financial Implications	Savings and revenue for fiscal 2004/05 will be $5.77 million.		
03/04 Redesign Plan Reference	*2.6*	***Link to VIHA Goals***	*#3 Create a sustainable and affordable public health system.* *#2 Ensure quality, client centered care and service*

4.6 *Professional Staff Mix*

Description	This is a phased initiative intended to reduce inconsistencies in the mix of licensed and unlicensed care providers in VIHA in acute and residential care while maintaining a high quality of care. The first phase involves a review of acute care nursing ratios VIHA wide. Across the country, the trend in health care is to increase the use and scope of duties of licensed practical nurses and unit based service aides (who may or may not participate in direct care activities). This trend has been driven by financial agendas as well as recognition of the need to support efforts to reduce the amount of time professional staff spend doing duties that can be performed safely by assisting personnel at a lesser cost. It is especially important to consider this in light of professional staff shortages.		
Progress Update	Over the past year data collection tools have been developed to ensure a consistent approach for a comprehensive review. Forty-seven units have been identified for review in the South Island and several units have been identified in the Central Island. Data has been collected for use with several different analytical models to understand the nature of the work on each unit as well as the operational statistics.		
Milestones for 04/05	• Finalize analysis of SI sites – May 04 • Discuss findings with VPs and RD's - May 04 • RD's to develop implementation plan(s) - Jun 04 • Implementation – South Island - varied - Oct - Dec 04 • Plan for evaluation of community sites - Sep 04		
Measures	• A comprehensive evaluation plan is being developed.		
HA Identified Challenges to Implementation	• Models of nursing care must be developed and/or modified • Availability of LPN staff for hire		
Financial Implications	Total savings for 04/05 will be $1.00 million		
03/04 Redesign Plan Reference	*2.10*	***Link to VIHA Goals***	*#3 Create a sustainable and affordable public health system.* *#2 Ensure quality, client centered care and service*

5.0 HOME AND COMMUNITY CARE INITIATIVES 04/05

5.1 *Restructuring – Community Care – Residential*

Description	The Home and Community Care (HCC) Redesign that began in 2002/03 will take on a new level of activity in 04/05 and into 2006/07. Significant investment will be made in complex care, assisted living, adult day care and various other community support options to better support the frail elderly and the disabled to live as independently as possible in the community. It is anticipated that these investments will also help to ease pressure on the acute care system by preventing unnecessary admissions to hospital and improving the rate at which people are discharged from hospital to a safe community alternative. Approximately 695 additional spaces will be added throughout VIHA between 2004 and 2006. These additions will be a combination of complex care and assisted living spaces. The greatest proportion of these new spaces will be added in the Central Island (473) in recognition of current shortfall in spaces and predicted growth. North Island will see an increase of 80 units and South Island, 142. By the end of 2006 VIHA's intends have a total of 5523 complex care and assisted living spaces comprised of 76% complex care (4205) and 24% assisted living (1318). With these increases VIHA will have 86 spaces per 1000 population over 75 years, which is just shy of the target rate set by the Ministry of Health Services. To achieve this goal, several facilities will be renovated to better meet the needs of complex care residents, several obsolete facilities will be replaced with a new facilities, new assisted living developments will be built, and existing private units may be purchased or added through rent supplements. Many facility upgrades and new developments are already underway. Two hundred and ninety new assisted living units were recently announced in May for 04/05. These units will be made possible through the Independent Living BC Program, a partnership of federal and provincial governments, health authorities, not for profit and for profit providers. In VIHA units will be spread out over 10 projects throughout VIHA: ➢ Laurel Lodge in Courtney - 75 units (rent supplements) ➢ Sea View Seniors Housing in Ucluelet - 10 units (new build) ➢ Arrowsmith Rest Home in Parksville - 30 units (conversion) ➢ Chemainus Health Care - 15 units (new build) ➢ Cowichan Indian Band Housing - 50 units (new build) ➢ Gulf Island Intermediate Care on Salt Spring Island - 30 units (new build) ➢ SCH Group - Sidney - 5 units (rent supplements) ➢ Cridge Centre for the Family in Victoria - 40 units (new build) ➢ West Shore Lodge in Colwood - 5 units (rent supplements) ➢ Luther Court Society in Saanich - 30 units (conversion) In the South Island a 22 bed convalescent unit will also be developed to better care for patients who no longer require acute care, but still require significant support while they recover from their acute episode. This unit will be located within an existing residential care facility yet to be determined. Further announcements regarding additional projects will be made as details are confirmed.
Progress Update	In 03/04 renovations were completed at the Oak Bay Kiwanis to enable the facility to take

	more complex care residents; 127 assisted living units were occupied including 12 units at the Ramada Hotel in Campbell River pending redevelopment of an existing long term care site in that area. At the same time Cumberland Lodge and Dufferin Lodge reduced their beds by 10 each to accommodate complex care. In Nanaimo 30 more assisted living units were added at Seniors Village. Other community programs expanded including day centers. An overnight respite service was established at Beckley Farm and Greenwoods (275 nights of client service for the year)		
Milestones for 04/05	The following is not an exhaustive list of all projects and timelines, but those with sufficient planning done to establish major milestones for this fiscal year. • Arranglen AL (Central) construction start - June • Sidney Seniors AL (South) - completion - Sept • Convalescent Care Unit (South) completion - Sept • Oak Bay Lodge AL (South) - completion - Sept • Lady Smith Multi Level Care (Central) - start construction - Fall • Pacifica Fisgard AL (South) - completion Dec • Laurel Lodge (North) - construction - Fall/winter • Arrowsmith Lodge (Central) - construction - Winter • Sea View AL (Central) - construction - Fall • Cridge Center AL (South) - construction - Fall • Luther Court AL (South) - renovation - Fall • Resthaven and Beckley Farm Lodge CC upgrade (South) - Fall • Langford Gardens (South) - construction - Fall • Yuculta Lodge - design complete - Spring 05		
Measures	• # of spaces completed • Alternative Level of Care Rate • Residential and Assisted Living Spaces rates/1000 • Preferred Placement Rate		
HA Identified Challenges to Implementation	This is a very large undertaking with many variables therefore susceptible to change. Milestones are preliminary and based on conservative estimates. Give the number of 3rd parties involved in these projects it is highly likely the timeframes will change. Changes in Ministry of Health Services policy and the impact of Federal/Provincial negotiations currently underway will also generate changes to this plan.		
Financial Implications	A notional allocation of an additional $9.7 million has been made to fund new complex care and to assisted living spaces which includes additional costs for home support.		
03/04 Redesign Plan Reference	*3.2*	***Link to VIHA Goals***	*#1 Improved health and wellness of VIHA residents.* *#3 Create a sustainable and affordable public health system.* *#2 Ensure quality, client centered care and service*

5.2 Restructuring – Community Care – Community

Description	The restructuring in residential care and assisted living will result in an increase in the number of home support clients as people in assisted living are aided by home support over the next two years. At the same time as these changes are taking place, VIHA will continue to examine who is currently receiving services and whether these services are appropriate and continue to be needed. For 04/05 a focus will be placed on home support services to adults with mental illness island wide. Many individuals with a mental illness have been historically served through the general home support program, but do not require the particular services for which home support was intended. Such individuals will be matched more closely to their needs within the Mental Health/Addictions Services and Special Needs Housing Programs.		
Progress Update	In the 03/04 Redesign Plan, VIHA identified a plan to focus services on home support clients with the highest needs, in keeping with provincial policy. The plan was to reassess clients at the personal care or intermediate care level 1 and make appropriate changes (eliminate services, reassess to higher levels of care and/or refer to alternative programs). As a result of this review 50% of clients at the lowest care levels no longer receive services and 47% are now receiving services at a higher level of care. The remaining 3% of clients are still under review.		
Milestones for 04/05	• Assess individuals using a mental health tool to determine actual needs and identify alternatives – Jun 04 • Work with clients to establish the change of service – Aug 05		
Measures	• Client concerns • # of adult mental health clients on general HS service by care level • # of home support clients at the intermediate care level 2 and higher • % of high needs clients receiving care at home • Budget variance		
HA Identified Challenges to Implementation	The key challenge will be to coordinate timing of changes with the numerous activities within Mental Health programs.		
Financial Implications	Total savings for 04/05 will be $3.63 million. The investment needed for home support associated with assisted living is included in the previous initiative (5.1).		
03/04 Redesign Plan Reference	*4.1*	***Link to VIHA Goals***	*#3 Create a sustainable and affordable public health system.* *#2 Ensure quality, client centered care and service*

6.0 ADULT MENTAL HEALTH INITIATIVES 04/05

6.1 *Mental Health Facility Services Redesign*

Description	This initiative is intended to redesign and plan the appropriate number and type of licensed and/or registered facilities in Mental Health and Addictions Services. This will involve the closure of some licensed facilities that are not designed to meet the meet the current needs of clients and redirecting these resources to more appropriate and lower cost alternatives. In addition a number of smaller measures will be taken to reduce costs. These include changes to modified work weeks, scheduling changes and small reductions in practise support.		
Progress Update	New		
Milestones for 04/05	• Facility and Service Planning Redesign - May 04 • Develop initiatives identified at strategic planning meeting - Jul 04 • Implementation underway - Sep 04		
Measures	• Client concerns • # of clients transitioned to alternative services • May not require hospitalization rates • Mental health alternative level of care rates • Budget variance		
HA Identified Challenges to Implementation	None identified		
Financial Implications	Total savings for 04/05 will be $0.06 million.		
03/04 Redesign Plan Reference	*N/A*	***Link to VIHA Goals***	*#3 Create a sustainable and affordable public health system.* *#2 Ensure quality, client centered care and service*

7.0 CORPORATE INITIATIVES 04/05

7.1 *Cost Recovery for Non-Insured Services*

Description	This initiative was first introduced in 03/04 with the aim of standardizing charges for hospital services to non-insured patients (e.g. out of country). For 04/05 these rates will be increased further province wide.		
Progress Update	Within VIHA rates for hospital services for non-insured patients were standardized in 2002/03. Rates were subsequently standardized across the province in 2003/04 and resulted in a substantial revenue increase for VIHA.		
Milestones for 04/05	Complete for 04/05		
Measures	• Budget variance for out of country hospital revenues		
HA Identified Challenges to Implementation	None		
Financial Implications	Total increase in revenue for 04/05 will be $0.15 million.		
03/04 Redesign Plan Reference	*5.1*	***Link to VIHA Goals***	*#3 Create a sustainable and affordable public health system.* *#2 Ensure quality, client centered care and service*

7.2 Downsizing Non-Contract Staff/Vacancy Management

Description	This initiative is a continuation of efforts to reduce the number of non-contract staff within VIHA that began in 02/03. These reductions should flow from other cost savings initiatives intended to find efficiencies through consolidation and new service delivery models. Savings will also be captured through attrition.		
Progress Update	Since 02/03 a significant number of non-contract staff have left the organization through early retirements, voluntary departure and lay-off. At the same time however, new Ministry directed programs have been initiated or organizations amalgamated with VIHA resulting in continuing challenges to meet desired reductions.		
Milestones for 04/05	• Vacancy freeze for all non-contract staff - in place		
Measures	• % change in non-contract worked hours		
HA Identified Challenges to Implementation	None		
Financial Implications	Total savings for 04/05 will be $0.40 million.		
03/04 Redesign Plan Reference	*5.6*	***Link to VIHA Goals***	*#3 Create a sustainable and affordable public health system.* *#2 Ensure quality, client centered care and service*

7.3 Obsolete Facility Closure – Gorge Road Hospital

Description	This is the third and final year of an initiative to close the Gorge Road Hospital and place residents in a more appropriate, safe environment. A secondary benefit is the savings realized from efficiencies in support areas and plant costs associated with a building that required ongoing remediation. Remaining steps to be completed include the relocation of Out-patient Rehabilitation Therapy to Victoria General and the Work Readiness Program off the site.		
Progress Update	All inpatient programs have been successfully transferred to other VIHA facilities and most outpatient programs have been transferred with the exception of rehab. The vacated extended care tower is currently being leased by the Central Park Care Homes on a full cost recovery basis to enable renovations at James Bay Lodge to be completed.		
Milestones for 04/05	• Complete move to VGH for outpatient rehab - Mar 05		
Measures	• Budget variance • Client concerns		
HA Identified Challenges to Implementation	No further challenges.		
Financial Implications	Total savings for 04/05 will be $1.37 million. No additional capital costs anticipated beyond those committed.		
03/04 Redesign Plan Reference	*5.8*	***Link to VIHA Goals***	*#3 Create a sustainable and affordable public health system.* *#2 Ensure quality, client centered care and service*

7.4 Administrative Support Restructuring

Description	This initiative includes a number of measures to reduce administrative overhead by 7%. Examples include consolidation of services, smaller outsourcing contracts and some internal service reductions. Most initiatives are fully implemented. Savings for 04/05 are the incremental amount to be realized with annualized implementation of previous measures. Additional savings and service improvement opportunities in back office functions will be investigated in 04/05. Where a business case can be made and where legislation and union contracts permit, VIHA will move forward this fiscal year, with the contracting out process for those functions determined to have greatest savings potential.		
Progress Update	To date financial accounting has been consolidated from 6 separate systems to two. Accompanying these changes have been consolidation of sites for financial operations. A wide variety of small measures have also been taken such as departmental restructuring for human resources, consolidation of transcription in Central Island and lowered internal support service levels for data and analytics.		
Milestones for 04/05	na		
Measures	• Budget variance • % administrative expenditure over 01/02 base budget		
Challenges to Implementation	None.		
Financial Implications	Total savings for 04/05 will be $0.54 million. No further capital investment required.		
03/04 Redesign Plan Reference	*5.9*	***Link to VIHA Goals***	*#3 Create a sustainable and affordable public health system.* *#2 Ensure quality, client centered care and service*

7.5 Contracting Out General Support Services

Description	The contracting out of general support services involves tendering work previously done by unionized staff, to private sector firms who are able to provide equal or improved service requirements at a significantly reduced cost. This initiative first began in 2002/03 and continues into 04/05. For this fiscal year VIHA will be implementing contracts signed for food and housekeeping services in selected South and Central Island locations. These contracts were in place prior to the recent agreement reached between the Hospital Employees Union and the Health Employers Association of BC.		
Progress Update	On March 16, 2004 contracts for food and housekeeping services were negotiated for selected south and Central Island locations. The contract for food services also included a provision for increased retail food services to generate revenue. In 2002, the Central Island laundry processing service was consolidated between the Cumberland Regional and Victoria Regional laundry processing facilities. Four small laundry operations were closed during this consolidation.		
Milestones for 04/05	Sites to transition from VIHA to contract provider for food and housekeeping in 04/05 • Cowichan District Hospital, Cairnsmore Place, Nanaimo Regional Hospital and Dufferin Plan - June • Saanich Peninsula - July • Aberdeen, Mt. Tolmie, Glengarry and Priory - Aug • Queen Alexandra Centre for Children - Aug • Victoria General Hospital - Sept • Royal Jubilee Hospital - Oct		
Measures	• Budget variance • Sick time for unionized staff • Compliance to contract standards (various quality indicators)		
Challenges to Implementation	The provincial cap on contracting out negotiated in May 04 will prevent health authorities from realizing the full benefits of the agreement previously negotiated with our provider for food and housekeeping services.		
Financial Implications	Savings and revenue for 04/05 will be $5.47million annualised to $8.23 million for 05/06. This total includes revenue, net wage saving from contracting out and reductions in VIHA overhead costs previously required to support employees.		
03/04 Redesign Plan Reference	*5.11*	***Link to VIHA Goals***	*#3 Create a sustainable and affordable public health system.* *#2 Ensure quality, client centered care and service*

7.6 Materiel Management Efficiencies

Description	This is the continuation of a set of initiatives started in 2003/04 to find efficiencies within the purchasing and supply chain. The initiatives include strategic alliances with primary vendors to gain rebates and value added services. These initiatives will be furthered in 04/05 and in some cases the scope of the initiative will be increased.		
Progress Update	2003/04 was a year focused on centralization and rationalization strategies. The number of information systems supporting Materiel Management was reduced from 3 to 2, a strategy for the implementation of Procurement Cards was completed and policies for patient transport were standardized. Also in 2003/04, eight vendors contributed and/or committed to a prime vendor or strategic vendor relationship with VIHA. This resulted in $415,000 in savings to VIHA while bringing $370,000 of value added opportunities to the organization.		
Milestones for 04/05	• Tendering for transport/courier services - May 04 • Pilot procurement cards - May 04 • Implement revised patient transport policy for acute care - Jul 04 • Finalize transport/courier contract - Jul 04 • Finalize implementation plans for consolidated warehousing - Jun 04 • Implement revised patient transport policy for residential care - Sep 04		
Measures	• Budget variance • Patient complaints/concerns • Internal customer complaints/concerns		
Challenges to Implementation	None		
Financial Implications	The total savings target for these initiatives in 04/05 is $0.60 million.		
03/04 Redesign Plan Reference	*5.12*	***Link to VIHA Goals***	*#3 Create a sustainable and affordable public health system.* *#2 Ensure quality, client centered care and service*

APPENDIX C

PERFORMANCE MEASURES AND TARGETS

VANCOUVER ISLAND health authority

Performance Measures and Targets - As At November 2003 *

Appendix C

GOALS	STRATEGIES	PERFORMANCE MEASURES	Target	Actual
Goal 1: Improved health and wellness of the people who live in communities served by VIHA	1. Working with Community Partners such as education, social services and housing to support residents of VIHA to make healthy life style choices	Immunization Rate for Children at 24 Months of Age	82%	81%
		Influenza Immunization Rate for Adults Living in Residential Care	85%	89%
		Alcohol Use - Self Reported Daily Alcohol Consumption	TBD	69%
		Self Reported Recommended Consumption of Fruits and Vegetables - Healthy Eating Habits	TBD	60%
	2. Prevent disease, injury or disability by working with community partners to implement core health prevention and protection programs	Self Reported Level of Physical Activity	TBD	57%
		Teen Pregnancy Rate for Age Group 15 - 19 Years	35.1	43.1
		Smoking Rates in Adults	15.0%	15% - SI; 22% CI/NI
		Body Mass Index (BMI) Rate - Acceptable Rate	100%	31%
	3. Working with community partners to focus on specific populations where there is a clear need and an ability to influence health	Communication - Web Site Average Unique Visitors	TBD	11,475
		Compliance with Clean-Air Bylaw	100%	99.7%
		Tobacco Sales Enforcement	100%	93.5%
		Life Expectancy of Aboriginal People	TBD	71.3 Years
		Infant Mortality Rates per 1,000 Live Births of Aboriginal People	TBD	17.7
Goal 2: Quality, client centred care and service	4. System redesign towards integrated delivery of health services across programs and by health service delivery areas (where appropriate)	Health Services Self Sufficiency	98%	94.6%
		Mental Health Services Self Sufficiency	98%	96.0%
		Staff Vacancy - Difficult to Fill Rate	0	2% BCNU; 1.5% Paramedical
		May Not Require Hospitalization Rate	6%	7%
		Percent High Need Clients Served At Home	45%	44%
		Residential Admissions per 1000 population over age 75	TBD	34.03
		Percent of Admitted Patients who wait more than 12 Hours in the Emergency Room	TBD	18%
		Admissions from Emergency as % of Inpatient Admissions	TBD	46%
		Ambulatory Care Sensitive Conditions (ACSC) Rate	TBD	3.6%
		Compliance with MOHS 90 Day Placement Policy	100%	76%
		CT Wait Time - % of "Urgent" procedures done within the standard	100%	100%
		MRI Wait Time - % of "Urgent" procedures done within the standard	100%	100%

VANCOUVER ISLAND health authority

Performance Measures and Targets - As At November 2003 *

Appendix C

GOALS	STRATEGIES	PERFORMANCE MEASURES	Target	Actual
Goal 2: Quality, client centred care and service (continued)	**4. System redesign towards integrated delivery of health services across programs and by health service delivery areas (where appropriate)** (continued)	Surgical Wait Time ("Booked" - "Surgery")- General Surgery	TBD	3 weeks
		Surgical Wait Time ("Booked" to "Surgery") - Orthopaedic Surgery	TBD	10 weeks
		Lab Turnaround Time for Emergency	40 minutes	< 40 minutes
		Alternate Level of Care Rate	TBD	9.5%
		Alternate Level of Care Rate - Mental Health	TBD	1.7%
		Days Over Expected Length of Stay	4.8	4.9
		Surgical Day Care Rate	65%	64%
		Unplanned Readmission Rate	TBD	6.6%
		Preferred Placement Rate	TBD	59%
		Client Satisfaction - VIHA wide	TBD	91.3%
		Client Satisfaction - Kidney Care Clinic	80%	88%
		Client Satisfaction - Laboratory	TBD	98%
Goal 3: A sustainable, affordable public health System	**5. Create a leading health care work environment to attract and maintain talented people throughout the health authority**	Worked Hours as a % of Paid Hours	TBD	81.9%
		Administrative and Support Services Expenses as a % of Total Expenses	24%	22.9%
	6. Develop and maintain effective partnership with government and community agencies	Hours of Nursing Care per Patient Day	TBD	6.0
		Sick Time as a % of Total Regular Paid Hours	4.0%	4.3%
	7. Review and update business models to support the strategic direction of the organization	Overtime Worked Hours as a % of Total Worked Hours	1.7%	1.8%
		Number of BCNU staff who worked more than 200 hours in a four week period	0	5
	8. Manage the delivery of services within the budget allocation from the Ministry of Health Services	Number of Injury incidents which result in time loss or medical aid per 10,000 paid hours	0.65	0.68
		Hire/Separation Ratio	TBD	1.7

* As at November 2003 - The data is from a variety of sources and thus the last available date for each indicator varies - for example, some measures may be from the year ended March 31, 2002 and some from March 31, 2003

TBD: To Be Determined SI: South Island Health Service Delivery Area CI: Central Island Health Services Delivery Area NI: North Island Health Service Delivery Area

APPENDIX D

SUMMARY OF POPULATION PRIORITIES

Appendix D – Summary of Population Priorities

Children and Youth

Strategies

a. Promote health of mothers and babies.
b. Improve the range and integration of services for children, youth and family.

Health of Mothers and Babies

VIHA recognizes the foundation for good population health is healthy babies and positive development in their first few years. Early childhood development is influenced by a wide range of factors including: maternal health nutrition and behaviors, early and ongoing physical, mental and intellectual stimulation of the infant, nutritional quality, the strength of family and social relationships and the quality of the physical environment. The benefits of focusing on early childhood development go beyond health to important societal concerns such as readiness and ability to learn, schooling, socialization and the prevention of violence and crime.

Children/Youth and Families

VIHA recognizes the need for a wide range of integrated services to meet the needs of children/youth and families. The pre-teen and teen years are critical in forming how youth will become productive adults in society. Teen pregnancy is a health and social concern, as it can affect a young woman's development and life opportunities. An unintended pregnancy exposes the parents and the child to a number of risks – physical, psychological, and/or social, which often begin a cycle of poverty and dependence (Provincial Health Officer's Report 2001).

Youth have health needs that differ from adults. To better address these health needs, VIHA will focus on providing more peer education, expanded hours, and gender sensitive programming. Some of the key initiatives include: providing information on healthy sexuality to youth in South Island high school districts, providing reproductive health services for youth with developmental disabilities and providing adolescent mental health services in collaboration with adult mental health services to ease the transition to adult mental health.

There will be a focus on preventing illness and injury and identifying and acting on chronic diseases, such as diabetes. Serious illness has a detrimental impact on a child and the family. By creating programs that assist in identifying and intervening on disorders and serious mental illness at the onset, these conditions become manageable, leading to an improved quality of life.

Aboriginal People

Strategies:

c. Establish effective working relationships with Aboriginal Communities.
d. Improve health status of Aboriginal people.
e. Improve the cultural sensitivity of services and improve the appropriateness of services used by Aboriginal people.

The health status of the Aboriginal population is well below the rest of the population in VIHA. Aboriginal people can expect:

- to live less years than the rest of the population (about 7 to 9 years less for Status Indians than the rest of the population);
- have higher potential years of life lost (about 2.5 to 3 times higher for Status Indians than for the rest of the population);
- higher infant mortality rates (about for 3 to 4 times higher for Status Indians than for the rest of the population); and
- low birth weights (about 1% higher for Status Indians than for the rest of the population).

Health is affected by many factors including housing, employment, income and education levels. Aboriginal people have suffered from poverty, unemployment and inadequate housing and drinking water. It is widely recognized that these are significant contributors to the inequities in health status between Aboriginal peoples and the non-Aboriginal population.

In order to begin to improve the health of Aboriginal people, there is a need to build better working relationships between Aboriginal people and VIHA. Specific initiatives planned and underway include:

- establishing Aboriginal Health Advisory Bodies and Working Groups to participate in Aboriginal health planning;
- delivering Culture Sensitivity and Communications workshops to build cultural competency among health authority staff; and
- conducting area health forums to facilitate community input.

There are significant differences in the use of services between Aboriginal and non-Aboriginal people. There are identified needs for more cultural sensitivity in the health service environment and for improved information sharing with this population on the availability and appropriate use of services. Some of the planned initiatives include:

- establishing hospital liaisons to provide support and assistance to Aboriginal people in feeling comfortable and safe during their treatment at a health service;
- conducting workshops to build the capacity of Aboriginal people to create Aboriginal specific health programming; and
- creating an inventory of health services available and conducting workshops and presentations to distribute this information to improve Aboriginal people's knowledge of available health services.

Frail Elderly

Strategy:

f. Improve access to health services for the frail elderly with the most complex care and multiple health needs.

VIHA has a growing and aging seniors population, particularly those over the age of 85 (projected increase of 28% by 2007). An increasing number of these residents are fragile with complex, multiple health issues. In the past, the majority of these individuals would have been admitted to residential care facilities. As the availability of community service options increases, VIHA will see an increase in the number of individuals with complex needs who choose to remain in their homes or in assisted living accommodation.

Seniors want to remain independent for as long as possible and want a choice in the type of service they receive and where they receive it. As a result, there is an increasing demand for choice, service options and service flexibility, as well as home adaptations to accommodate aging in place.

VIHA is creating a network of community options, which will address the needs of seniors and adults with longer-term care/service needs. The plan is to move the reliance for seniors' support away from facilities and into communities, and to emphasize independent living, self-care and choice.

The network is an array of care and living options that includes: home support; community supports such as bathing programs, adult day programs, respite care, sub-acute programs such as the Geriatric Evaluation and Management program, mental health housing and community resources; complex care (facility-based care for those clients who require 24-hour service), palliative care and assisted living.

VIHA will be working with existing community agencies that provide services such as adult day programs and home support to increase the capacity to serve individuals with higher support levels. VIHA, in partnership with BC Housing, will increase the availability of supportive living options. As assisted living units and community supports continue to be established, many residential care facilities across the island will be closing their intermediate beds and upgrading to provide complex care. These units will be assigned specifically for clients with the most complex needs through the application of the new assessment tool for residential care (MDS V2.0).

Adults with Mental Illness/Addictions

Strategies:

g. Develop an integrated system of services for people with mental health and addictions problems.

h. Enable people to remain in their community with supports designed for their needs.

VIHA mental health and addiction services are designed to serve people with mental illnesses and/or substance misuse problems. Approximately 50% of people who suffer from mental illness have concurrent substance misuse problems.

VIHA is moving towards an integrated approach to assessment, treatment and services to clients with mental illness and addictions. VIHA has adopted a framework (the Comprehensive, Continuous Integrated System of Care model) for the overall management of an integrated system of care for people with mental health and addictions problems.

A $6.47 million Mental Health Renewal Initiative represents a significant investment in community services, recognizing client needs. The new funding will support over 24 initiatives aimed at strengthening the continuum of flexible support services to keep clients in their community. These include creating a needs-based service delivery model and establishing a continuum of flexible housing options. Initiatives to provide education and support for people with serious and persistent mental illness, providers, care givers/families and the public are also included. These services will be client focused, will ensure accessibility, and wherever possible, will meet contemporary standards.

The Mental Health Renewal Initiative will support people in their communities. It will enable individuals to manage their illness, stay healthier and improve their quality of life. It will also assist in alleviating acute care pressures by improving clients' access of services and minimizing length of hospital stays through carefully planned transitions to community and alternative care.

Downtown/Hard To Serve

Strategy

i. Improve access to health services for underserved populations.

Many people in downtown Victoria and Nanaimo are unable, for a variety of reasons, to access the health services they require. The homeless, people living in under-housed conditions, street youth, drug users, and people with mental health and/or substance misuse problems experience a number of barriers to entering the health system. Barriers include limited operating hours of health facilities, negative past experiences with health service providers, lack of transportation and the lack of health services that respond to specific health needs.

Underserved populations need better access to health services. Approximately 70 to 80% of people living on the streets or at risk of becoming homeless suffer from substance misuse problems and debilitating mental illnesses. To target mental health and addictions problems in the downtown/hard to serve population, VIHA has created a partnership with the City of Victoria and the Victoria City Police to create the Downtown Health Initiative.

The Downtown Health Initiative Action Plan identifies six short term actions and four long term actions that aim to reduce potential threats to public safety, improve access to detox, treatment and mental health services, and increase the supply of transitional and long term affordable housing. Specific short-term actions include creating a sobering centre, expanding youth detox services, adding additional outreach street workers, increasing the needle pick up program and improving intake procedures for psychiatric emergencies. The longer term actions include developing more harm reduction strategies downtown, building a new psychiatric emergency building at Royal Jubilee Hospital and creating a downtown health coalition to maximize the use of all health services in the most effective way.

Persons with Disabilities

Strategy

j. Promote independent living for people with disabilities.

Disabilities can result from many causes including those developed at birth, acquired injuries and diseases and the effects of advanced aging. Persons with disabilities are a diverse population with different capacities and needs. Many of these needs can be safely and best met in the person's home or community.

VIHA has identified persons with disabilities as a priority population. VIHA delivers a number of programs and services that support people with disabilities to live independently and participate more fully in the community. These programs include Independent Living BC, Choice in Supports, Community Living Services and Brain Injury.

VIHA, in partnership with B.C. Housing, will increase availability of supportive living options. The two types of housing for persons with disabilities are: independent housing with some support services and assisted living for those who need a greater level of care. VIHA will implement and evaluate two pilot projects of assisted living for people with disabilities.

Chronically Ill

Strategy

k. Effective management of chronic disease to prevent or slow disease progression.

Chronic diseases are long-term and life threatening illnesses that have a profound effect on the physical, emotional and mental well-being of individuals. In many cases, the effective management of chronic diseases can minimize or delay deterioration in health. Chronic disease management is a systematic approach to care that emphasizes helping individuals maintain independence and keep as healthy as possible. This is done by prevention, early detection, and effective management of chronic conditions, such as: diabetes, hypertension, congestive heart failure, asthma, depression, renal failure and other debilitating illnesses.

As part of the $7.5 million grant for primary health care from the federal/provincial primary health care transition fund, VIHA will create two initiatives directed to chronic disease management.

For the South Island, VIHA will design, build and implement a new and sustainable approach to organizing and delivering chronic care. It will serve patients with depression, diabetes and congestive heart failure using B.C.'s Expanded Chronic Care Model as a foundation (Ministry of Health Services Website). This model identifies essential elements in a system that strives for enhanced chronic care management within the population. It will demonstrably improve the process of care for the chronic disease patients and start showing health status improvements in selected clinical scenarios. Upon successful implementation, the intent of the project is to inform others about the value of the approach and expand the model across VIHA.

VIHA will also initiate a Chronic Kidney Disease (CKD) project that will take a region-wide approach. VIHA will design, build and implement a model to demonstrably improve the process of care for CKD patients. The model will be implemented in various geographical locations and settings including at least two underserved communities. It will be based on subgroups of patients, depending on their stage of CKD. These subgroups will be "upstream" from the population traditionally served by CKD teams. Patients with CKD living in VIHA will benefit from increased services and more equitable access to them, in order to successfully co-manage their disease with primary and specialist care providers.

Rural and Remote

Strategy

1. Enhance access and service quality for rural remote communities.

VIHA's geographic area covers 56,000 square kilometers and includes Vancouver Island, the Gulf and Discovery Islands and a small mainland area opposite northern Vancouver Island. The area includes many remote and isolated communities such as Quatsino, Sointula, and Alert Bay that are only accessed by water or air. About 20% of the population of VIHA live in rural areas compared to 15% in the province. Ensuring access to services in these rural and remote areas is a priority to VIHA. The following is an overview of the key initiatives within VIHA that are aimed at addressing this population need.

VIHA Mental Health and Addictions Services has created a $6.47 million Mental Health Renewal Initiative, which represents a significant investment in community services, recognizing client needs. As part of the new funding, initiatives have been created that will address the mental health and addictions needs in smaller communities, particularly in the Central and North areas.

One of the rural and remote areas of VIHA is the north part of Vancouver Island – Mt. Waddington area. VIHA is in the process of creating a Primary Health Care Plan dedicated to this area. Primary health care is a vital component of the health services system that provides a comprehensive range of services that focus on activities such as health promotion, preventative care, episodic treatment, and disease management. The plan is based on a regional virtual network with strategies to promote better access to services and integrated use of resources among providers in population centres. Individual communities will design specific quality initiatives based on their population health needs.

The Provincial Health Services Authority telehealth program is key to linking rural communities to highly specialized services. Residents in rural communities can benefit from telehealth by tapping into the expertise available in urban areas while avoiding time consuming, and sometimes difficult travel. VIHA recognizes the opportunities the telehealth program provides and is participating in a telehealth pilot project through the BC Cancer Agency. This project is aimed at enabling post-diagnosis follow up appointments for patients in the central island area with an oncologist in Victoria.

The BC Women's Hospital and Health Centre has created a new Advanced Maternity Fellowship for Rural Practitioners. This fellowship was established to help provide comprehensive maternity care to women around the province. VIHA is the first recipient of the fellowship, which will provide training for a group of nine registered nurses from hospitals serving Northern Vancouver Island.

APPENDIX E

ACUTE CARE – FACILITIES AND KEY STATISTICS

Appendix E – Acute Care – Key Statistics

Table 1: Select Data for Acute Facilities within VIHA

VIHA ACUTE FACILITIES: SELECT DATA										
LHA	LHA Pop'n 2002	GPs by LHA 02/03	SPs by LHA 02/03	*Hospital*	Hospital Category	Acute Beds* 2003	Surgical Cases (2002/03)**			Deliveries 2002/03 ***
							In-Patient	Day Surgery	Total	
Victoria	209,269	339	324	Royal Jubilee	Tertiary Hospital	863	7,646	6,426	14,072	0
				Victoria General Hospital	Tertiary Hospital		7,086	5,242	12,328	2,718
				Queen Alexandra Centre	****	20	0	0	0	0
Saanich	61,461	83	41	Saanich Peninsula Hospital	Community Hospital	48	420	1,661	2,081	16
Gulf Islands	14,518	26	10	Lady Minto Hospital	Community Hospital	18	69	89	158	22
Cowichan	52,602	62	37	Cowichan District Hospital	Community Hospital	105	1,463	1,888	3,351	453
Ladysmith	16,479	18	4	Ladysmith	Community Health Access Centre	22	0	640	640	0
				Chemainus Health Centre	Community Health Access Centre	0	0	0	0	0
Nanaimo	93,889	106	93	Nanaimo General Hospital	Regional Specialty Hospital	241	3,715	6,168	9,883	1,048
Alberni	31,662	32	11	West Coast General	Community Hospital	52	626	798	1,424	194
				Tofino General Hospital	Remote Hospital	10	0	0	0	33
				Bamfield*****	Outpost Station	0	0	0	0	0
Courtenay	58,252	76	47	Cumberland	Community Health Access Centre	0	0	131	131	0
				St. Joseph's Hospital	Community Hospital	109	1,423	2,575	3,998	563
Campbell River	39,735	52	21	Campbell River Hospital	Community Hospital	59	941	1,982	2,923	361
VI West	2,463	1	1	Kyuquot*****	Outpost Station	0	0	0	0	0
				Gold River	Community Health Access Centre	0	0	0	0	0
				Tahsis	Community Health Access Centre	0	0	0	0	0
VI North	13,916	14	0	Port Hardy Hospital	Remote Hospital	12	0	0	0	10
				Port McNeil Hospital	Remote Hospital	10	0	0	0	4
				Cormorant Island Health Centre	Remote Hospital	4	0	0	0	2
				Port Alice	Community Health Access Centre	0	0	0	0	0

* Acute Beds are the working capacity bed base as of January 2004 (Royal Jubilee/Victoria General beds include 22 special care nursery bassinets)

**This includes surgical day care but excludes minor procedures.

***Does not include deliveries that were at home.

**** Queen Alexandra Hospital provides tertiary level child and mental health services but does not provide emergency and surgical services.

***** Bamfield and Kyuquot are geographically located in VIHA but administered by the Provincial Health Services Agency.

Table 2: Select Acute Care Data by HSDA as Compared to VIHA and the Province

2001/02	Weighted Cases*/1,000 Population 2002/03	% Change 1997/98 to 2002/03	Acute/ Rehab In-Patient Days/1,000 Population 2002/03	% Change 1997/98 to 2002/03	Self Sufficiency (% of acute Weighted Cases provided locally) 2001/02	Acute/ Rehab Average Length of Stay 2002/03	Alternate Level of Care Days as a% of Total Days 2002/03
South	120.4	1.5%	570.8	(3%)	95.2%	7.5	15.4%
Central	123.1	(6.2%)	578.8	(3.1%)	70.9%	6.4	8.8%
North	145.0	(5.5%)	631.0	(4.2%)	65.5%	5.9	15.0%
VIHA	124.7	(2.3%)	581.9	(3.2%)	93.7%	6.8	13.2%
Province	120.5	(11.1%)	535.0	(13%)		6.5	13.3%

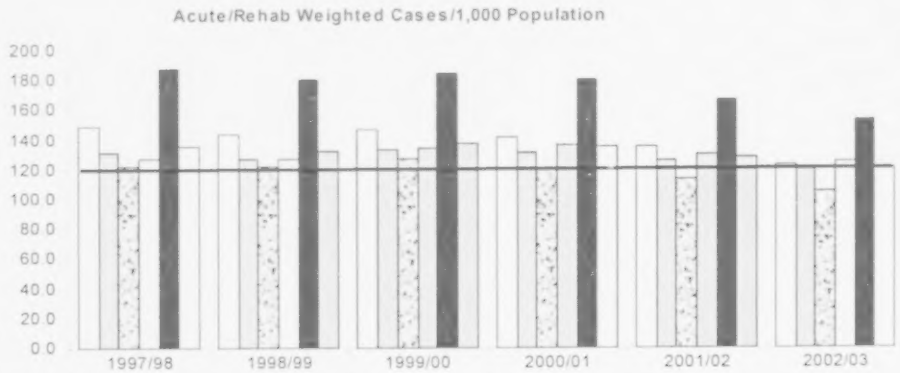
*Weighted cases are cases, which are adjusted for acuity – that is a case such as a hip replacement would count as more than a hernia repair.

Sources:

Discharge Abstract Database, Information Support, BC Ministry of Health Services

BC Ministry of Health, Health Service Redesign Plan Revised March 2003

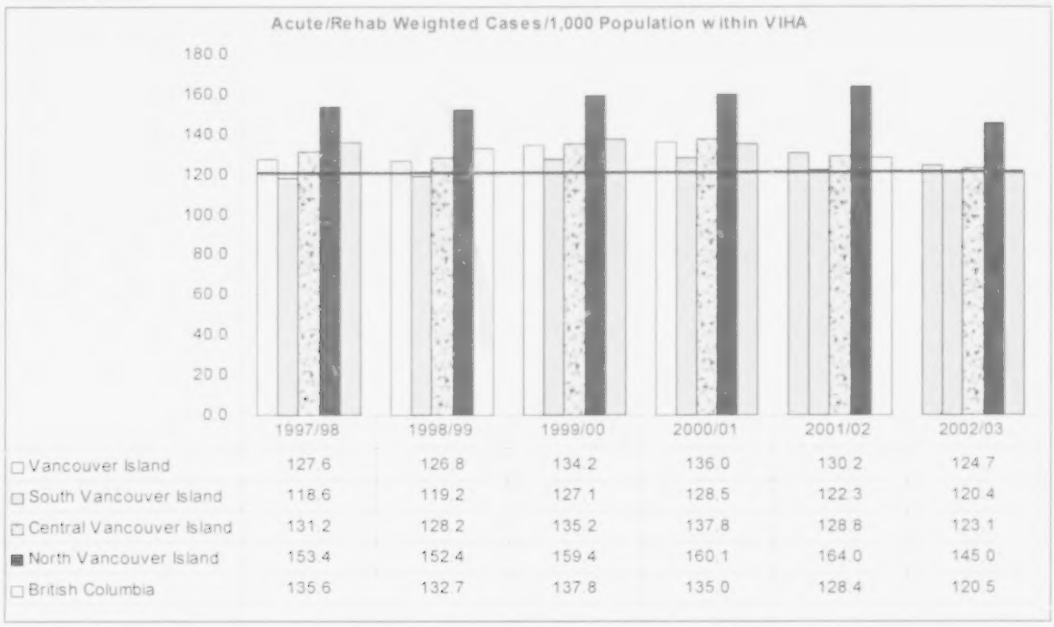
Figure 1 – Acute/Rehab Weighted Cases/1,000 Population (age standardized) by Health Authority



	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03
Interior	148.9	143.5	146.7	141.7	135.7	122.6
Fraser	131.4	127.4	133.2	131.7	125.7	120.7
Vancouver Coastal	122.2	122.3	127.1	121.2	113.4	105.1
Vancouver Island	127.6	126.8	134.2	136.0	130.2	124.7
Northern	187.6	179.8	184.5	180.5	166.4	153.0
British Columbia	135.6	132.7	137.8	135.0	128.4	120.5

Source: Discharge Abstract Database, Information Support, BC Ministry of Health Services

Figure 2 – Acute/Rehab Weighted Cases/1,000 Population Within VIHA (age standardized)



	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03
Vancouver Island	127.6	126.8	134.2	136.0	130.2	124.7
South Vancouver Island	118.6	119.2	127.1	128.5	122.3	120.4
Central Vancouver Island	131.2	128.2	135.2	137.8	128.8	123.1
North Vancouver Island	153.4	152.4	159.4	160.1	164.0	145.0
British Columbia	135.6	132.7	137.8	135.0	128.4	120.5

Source: Discharge Abstract Database, Information Support, BC Ministry of Health Services

APPENDIX F

SUMMARY OF RESIDENTIAL CARE

Appendix F – Summary of Residential Care

2002/2003	Residential Beds		Bed Rates	
HA & HSDA	Beds	Rates per 1,000 Pop'n 75+	HA Rank (1 to 5)	HSDA Rank (1 to 16)
Interior	4,512	86.5	2	
East Kootenay	476	99.8		10
Kootenay Boundary	707	118.1		14
Okanagan	2,340	78.9		3
Thompson/Cariboo	989	84.4		5
Fraser	7,554	96.7	3	
Fraser Valley	1,458	88.2		7
Simon Fraser	3,263	114.0		12
South Fraser	2,833	86.0		6
Vancouver Coastal	7,061	111.7	4	
Richmond	651	68.1		1 (lowest)
Vancouver	4,705	130.5		15
North Shore/Coast Garibaldi	1,704	96.7		9
Vancouver Island	4,959	83.7	1	
South Vancouver Island	2,983	89.5	(lowest)	8
Central Vancouver Island	1,479	74.9		2
North Vancouver Island	497	80.0		4
Northern	1,049	120.5	5	
North West	272	115.5	(highest)	13
Northern Interior	516	113.6		11
Northeast	260	144.2		16 (highest)
Provincial Total	25,135	96.1		

Source: BC Ministry of Health Services, Information Support, Corporate Services and Financial Accountability (Crude Rates, total beds per 1,000 population age 75+)

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